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ABSTRACT

This document contains 14 papers that examine recent changes in the definition, principles, and delivery of population education throughout the world. The paper titles are as follows: "Introduction" (Linda King); "Reaching Men for Health and Development" (Benno de Keijzer); "Boys, Men and Questions of Masculinity in South Africa" (Robert Morrell); "Educating Men to Participate in Reproductive Health Programmes" (Imtiaz Kamal); "Cultural Aspects of Reproductive Health Education in the Arab World" (Toufic Osseiran); "The Adolescent in Today's World: Considerations of Sexual and Reproductive Health" (Cristina Fuentes Zurita, Clara Ines Charry Sanchez); "Information Provided by Rural Mothers to Their Daughters Concerning Reproductive Health" (Chanya Sethaput, Pimonpan Isarabhakd); "Ageing in Cuba" (Raul Hernandez Castellon); "The Effect of Fertility in China" (Xu Mingdong); "Adult Education and Population in Ghana: Strategies for Empowering the Ghanaian Woman" (Miranda Greenstreet); "Gender and Health Education: The Incidence of Cervical Cancer in Jamaica" (Patricia Rodney); "Reproductive Health, Education, and Risk in Cuban Society" (Alina C. Alfonso Leon); "Sex Education in Cuba: Recent Initiatives" (Maria Antonia Torres); "The Role of Adult Education in Population Issues in Zimbabwe" (Mercy

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Hatendi); and "One Night in Bangkok" (Wilas Lohitkul). Several papers include substantial bibliographies. (MN)

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QUESTIONS OF INTIMACY RETHINKING POPULATION EDUCATION

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Questions of Intimacy
Rethinking Population Education

Linda King (ed.)

UNESCO Institute for Education (UIE)

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Several participants in the seminar are not mentioned in the publication but were crucial to its success. Leslie Pascoe provided endless hours of perfect translation and goodwill, Sandra Aliaga was a resource person as was Benno de Keijzer. Cristina Grela, Elena Martínez Canals, Maria Teresa Díaz Alvarez and Mercedes Fabros also participated with key presentations which helped shape the discussion throughout.

With regard to the publication itself, as any editor knows, books are not always simple outcomes of seminars. Angela Ronai helped with the technical editing of some of the papers while Sonja Schiman completed the time-consuming and meticulous task of incorporating the corrections and formatting the final version.

Linda King

Preface

In development policy, the most difficult process of revision and yet the most influential, is the shift of paradigms. To undertake such a renewal of perspectives, in a domain where policies touch on intimate areas of life and where the grand narratives embedded in other contexts do not often connect with the present risk faced by women and men of today, is even more delicate and difficult. This book, produced under the intellectual leadership of Linda King, fulfils this task remarkably and in many different ways: extending at last the gender question to men as well as women, daring to re-link reproductive health to the broad reality of sexuality, revising the predominant linear mode of communication in health promotion in favour of a practice of dialogue acknowledging the subjectivity of the processes involved, and, above all, relying on the creative participation of men and women. It is so refreshing, in this domain, to read authors who have refused to restrict the population issue to a demographic explosion and population education to the strict adoption of the "best" behaviour.

This change of paradigm here is not an academic exercise. It comes out of hard confrontation with reality and it transforms practices and policies. Behind this epistemological shift lies the hope for millions of women and men to become free of violence, to have space for reproductive choice, to prevent severe sickness, to enjoy creative ageing, to live with dignity.

As we say in my country of origin, this book is "fun". This publication about population deals not with problems but with people; it respects them; it recognizes their various cultures; it looks at their different ways to learn throughout life and to transform reality. It also invites men to engage into a long awaited dialogue among themselves and with women on masculinities, feminities and sexual stereotypes. I, for one, take up the invitation.

Paul Bélanger
Director UIE

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Introduction

Redefining Population Education

Population education is in the throes of redefinition as the contributions to this book illustrate. Just as the population field itself has been critically reconstructed in the pre- and post-Cairo years of the past decade, so too have the substantive and semantic contents of adult learning programmes. A quick glance at some of the topics relating to the field of population education and contained in this volume underpins this point: sexuality, AIDS education, women's empowerment, ageing, male involvement, masculinities, inter-generational learning, violence, reproductive rights, adolescence, fertility and education, and cultural context are just some of the issues discussed. "Family planning" in its restricted sense and the achievement of quantitative demographic targets, although still present in the discourse, are less the focus of attention.

The present volume is a selection of the main papers presented at an international expert group meeting held in Cuba in December 1998, organised by the UNESCO Institute for Education with the support of the UNESCO representative office for Cuba and with funding from UNFPA and CIDA-Canada. The seminar was a follow-up activity to the Fifth International Conference on Adult Learning (CONFINTEA V), held the previous year in Hamburg, during which a workshop had taken place on population education in the post-Cairo context. During this workshop the discussion had emphasized the epistemological shift which had been taking place in the population field itself. This change in both the subject and meaning of the population field had been a process spurred on in particular by the international women's movement, by international agencies and by national governments. It was stressed in CONFINTEA that the agreements reached during

the Cairo meeting in 1994 needed to be translated into practical policies, particularly in the field of adult education.

In the following sections, and by way of an introduction to the papers presented in this volume, I discuss some of the emerging issues in population education for the 21st century. I begin with the discussion on education and fertility and the new demographics of ageing. I then focus on reproductive rights and the rights approach to population education, the cultural context of population issues, the role of NGOs, and gender in the population field understood both from the perspective of women´s empowerment and what has come to be termed in the literature as "male involvement".

Education and Fertility

Education has always been intrinsically linked to population issues. Numerous studies have noted the relationship between fertility rates and women's level of education. The figures shown below indicate that the higher the female literacy rate the lower the number of children per woman.

Female literacy rates and fertility rates, 1995[1]

Female Literacy	Number of children per woman
Less than 20%	6.0 children
21-40%	5.7 children
41-60%	5.6 children
61-80%	4.3 children
More than 80%	2.7 children

Overall and despite general trends of improvement, the statistics demonstrate women's uneven share in the educational wealth of nations. In 1995, there was only 47% female literacy in Sub-Saharan Africa, as opposed to 66% male literacy and in India only 37% female literacy, compared to 65% male literacy.

In Latin America, the gender gap has almost been closed between male and female rates of literacy however. With regard to enrollment rates for girls, the situation has likewise improved, but marked gender differences still persist in Sub-Saharan Africa, the Arab States, and Southern Asia.[2]

On the one hand, at a macro level, it may be argued that countries with higher population rate growths tend to produce more illiterate people as educational demand outweighs the possibility of response to that demand. The argument is founded on the notion of limited good, meaning that not everybody will be able to share in a piece of the educational cake. Hence, the higher the fertility rate, the lower the educational level of the general population, with the poorest having less access both in terms of educational facilities and in the amount of time which can be afforded to education, as opposed to income generating activities. UNESCO has recently charted an association between illiteracy and fertility in developing countries and established a correlation between the number of children and the levels of illiteracy.[3] However these statistics need to be viewed with caution since the figures vary markedly between urban and rural areas. Women tend to have larger families in rural contexts where child labour is valued and where concomitantly education is not. On the other hand, the demand for educational qualifications in urban areas has a converse effect on the numbers of children.

In studies carried out in Latin America, multivariate analyses have pointed to women's education as the most powerful and significant independent variable affecting fertility rates even taking into consideration other socio-economic variables.[4] At a micro level there are several possible hypotheses for this. The first is that educated women tend to marry later, hence reproductive activity is postponed as a result of participation in schooling. A second is that, as women and

girls become more educated, their status and income-generating possibilities within the family increase and they can make more independent choices with regard to their reproductive activities, which are, in turn, respected by their spouses and families because of their economic status. Indeed, this change in status probably encourages participatory joint decision-making in the domestic sphere. Thirdly, as education increases girls' self-esteem and self-awareness, it gives them the confidence to challenge the *status quo*, and to propose their own reproductive choices. Finally, there is the hypothesis that more educated women and girls are aware of the health implications linked to bearing a large number of children and are in turn more informed about family planning options.

At the same time, however, it has to be acknowledged that illiteracy *per se* is associated with other measures of poverty, malnutrition, poor health, etc., while literacy is associated more with urban lifestyle, greater exposure to the media including radio and television, and greater mobility. In this regard, das Gupta (1997), in a thought provoking paper on fertility decline, goes beyond the argument relating this to levels of education and looks at the historical evidence linking fertility decline with levels of democratic governance related to changes in socio-political institutions. It is her contention that these developments have permitted internal changes, as people become more empowered by the social and political contexts to make their own decisions particularly with regard to reproductive choice.

The Ageing Population and Education

Despite the overall reduction in the global fertility rate which now stands at 2.7 births per woman, (having fallen from 5 births per woman over the past 50 years) the world's population is projected to continue growing and to approach 9 billion by the middle of the 21st century. To a certain extent this is due to

the growth of the world's population over 60 years of age. This is a phenomenon that is happening not only in the industrialized societies but also in the developing world. By the year 2020, the number of older people worldwide will reach more than 1 000 million with over 700 million in developing countries. Europe will be the oldest region in the world with around 25% of the population over the age of 60, but the oldest country will be Japan with 31%. In terms of absolute numbers, however, China will top the tables with 230 million older people, followed by India with 142 million.

As the composition of the world's population changes, moreover, so do the key issues involved. The so-called "greying" of the population, with extended life expectancy and reductions in birth rates, is leading to new challenges for education for a population that is older and with specific needs and with educational problems related to that. In Germany, to take just one European example, today there are sixteen people over 65 for every baby under the age of one year, compared to 40 years ago when there were just six people over 65 years of age for every baby under one year old. Taking UNDP´s low growth projections moreover, by the year 2050 the median age in Germany will be 55 and in Italy 58. And, looked at regionally, this will contrast in Asia with a young, mostly male population.

Not only does this demographic shift have political and economic implications but it also has an impact on the social and educational services which populations demand from national governments. There are likewise profound implications for the growth of multicultural and multiracial societies in industrialized societies. Immigrant populations are tending to grow at a faster rate than the national majority population. This means that while the younger population will be more racially and culturally mixed, the older population will be more mono-

ethnic and less racially mixed. At the same time, it will be the older, predominantly feminine, population which will form the main body of the electorate, for example, women over the age of 50 will form 31% of the total voting electorate in Italy and Germany. The political weight of older women in this changing context moreover, will, according to some authors, lead to a feminization of politics.[5]

Reproductive Rights

The most important development occurring as a result of the new population discourse has been the move from a focus on the threat of the "population explosion" with all its nuances of global disaster to one centring on reproductive and sexual rights. Reproductive rights entered the arena of human rights, as a new kind of rights issue, involving control and ownership of the body and focusing particularly, although not exclusively, on the right of women to make decisions about their reproductive futures. The notion of reproductive rights has, as do all social concepts, a history and as such is embedded in social movements[6]. Initially, human rights discourse had to do with civil and political rights, later there was a more explicit focus on social rights, and more recently the notion of reproductive rights has come to be included in the international discourse on human rights. In addition to this, as Pitanguy has pointed out, the very notion of human rights as enshrined in the *Universal Declaration of Human Rights* reflected the dominant male view of the world order in the era following the Second World War[7], and as such was limited by its own gendered history. The feminist movement internationally has, therefore, been questioning the whole notion of human rights and pushing for specific women´s rights within these.

UNFPA defines reproductive and sexual rights in four key dimensions:[8] the right to reproductive and sexual health; the right to reproductive decision-making (including the right to

access to information); the right to equality and equity for men and women (including freedom from gender discrimination) and the right to sexual and reproductive security (including freedom from sexual violence and coercion). However, in order to make effective decisions regarding reproductive rights, women and men need to receive information about their options and the implications of these. This is where adult education plays a key role. For, despite all the advances of the past decades, reproductive health continues to reflect the abysmal situation affecting women in many countries, and to illustrate the devastating inequalities between the different regions of the world. To highlight the figures on maternal mortality: whereas in Africa one woman in 16 risks dying in childbirth, in the United States, on the other hand, only one woman in 4 000 is subject to this risk. From the AIDS field are even more chilling reminders: in Zimbabwe alone one person in every four is estimated to be HIV positive. Indeed, 90% of all those infected with AIDS live in countries of the South. And in those countries in Africa with the highest incidence of HIV/AIDS average life expectancy has been reduced by up to 7 years.

The Rights Approach to Population Education

The rights approach to population education focuses on reproductive and sexual rights within a framework of the right to learn. *The Agenda for the Future*, one of the documents emanating from the Fifth International Conference on Adult Education, frames the right to learn in the area of population issues as a commitment to:

Article 36. Promoting adult learning on population-related issues and family life, by enabling people to exercise their human rights, including reproductive health and sexual health rights and develop responsible and caring attitudes.

Article 37. Recognizing the decisive role of population education and health promotion in preserving and improving the health of communities and individuals.
Article 38. Ensuring cultural and gender-specific learning programmes.

The new context of adult learning incorporates the experience of learners as an important factor both in determining their larger learning aspirations and the learning contexts themselves. To this extent, therefore, the right to learn is intricately related to the right to be recognized and to have one´s experience and competencies validated. In this respect, the notion of cultural rights or the right to freely express one's beliefs and values through culture, is part and parcel of educational and sexual rights.

The key issue is, once internationally recognised written agreements such as the ICPD document or the Agenda for the Future coming out of CONFINTEA V have been agreed, how to move on in terms of concrete policy implementation. The role of adult education, from this perspective, therefore, should be to provide information and social spaces for discussing and debating the new focus and for providing a context for moving from global agreements to local community and people centred initiatives. From the right to reproductive decision-making we move to the right to learn. By adopting a human rights approach to reproductive issues and to adult learning issues we can begin to see how the two may interact in a framework of human rights education, which support both the right to learn and the right to make informed reproductive choices.

Gender: from Women's Empowerment to Male Involvement

Women's empowerment is an often expressed component of reproductive health programmes. However, it is often unclear

exactly what is meant, and the term is used in many ways, which has led to it developing a virtual *cliché* status. Who empowers whom, whether governments can empower, whether development programmes can incorporate empowerment, and whether empowerment can be measured, are just some of the questions thrown up. As Batliwala (1994) has rightly pointed out, women's empowerment came to be seen as a panacea for all social ills, meaning all things to all people. Sen (1997) has drawn out the essential distinction. Governments and development agencies may provide enabling environments but it is only people, and in this particular case, women, who can empower themselves. Empowerment is not, in other words, something that can be done by someone to someone else.

More recently there has been a move from stressing women's empowerment in the population field to emphasizing the inclusion of men in reproductive health strategies. Male involvement has become a key issue, with governments and NGOs realizing that, while women's empowerment is a key concern, in terms of reproductive rights and choices these affect both men and women. There has been a growing movement for men to get involved both in questioning and redefining their own masculinities and in working together with women for just and fair societies based on gender equity.

The notion of gender itself continues to be a source of discussion and debate. It was introduced initially as a concept designed to explore male-female relations and to move away from the essentialist position, which referred to women as a category without relation to men. Nowhere is it more evident than in issues of sexuality and reproductive health, however, that it is meaningless to talk of women without men, and vice versa. For reproduction in the majority of cases is about male-female sexual relations as these are conditioned by social, economic and cultural circumstances. And gender is precisely

about the distribution of power between the sexes, and social groups based on gender identities, which in turn determine the decision-making processes.

In the field of education, gender is a concept which permits us to understand the differing ways of rearing children according to whether they are male or female, and the expectations which society places on those members, according to their gender identity. And through an understanding of gender relations in different contexts we can come close to answering some of the questions related to population issues, and adult education, such as: the choice of number and spacing of children, the practice of contraceptive techniques (both male and female centred), the social significance of maternity and paternity, of male and female sexuality, power relations within the family in whatever form it takes, and the reproductive health of all members of society.

Educational discourse for the 21st century is founded on the notion of lifelong learning. This has particular relevance for gender relations, which change throughout life, as do patterns of sexuality and reproductive behaviour. Gender analysis enables us to discover or reveal these changing relations and their relevance for educational needs within a framework of learning throughout life. In particular, within the educational context, and more specifically in adult education scenarios, the challenging of gender stereotypes or of the idealized 'man' and 'woman', permit the reconstruction of individual and group identities more in tune with changing demands of justice and freedom.

In turn, gender is conditioned by the beliefs held within different cultures. Education, both in the family and in the school, reinforces these belief systems as the prominent ones of that particular society. Child rearing, the social reproduction of roles, and the division of labour in any particular society is, moreover, directly related to gender identity. Indeed, this simple

fact, namely that reproductive roles have been dichotomized by gender identities has formed the basis of the Western feminist critique for many years. The limitation of women's identities to the reproductive role of mothers and child rearers has throughout history been the norm. And the challenging of these stereotypes, brought about largely through education, has involved reconsidering the relation between gender and reproduction. One particularly notable phenomenon in this regard is that of the 100 million missing girls and women from the population of South-central Asia and China. Demographers estimate that they are missing by virtue of infanticide, selective abortion, negligence and malnutrition. UNESCO´s recent report on education and population dynamics highlights this issue and suggests that it will only be through education that more egalitarian views of boys' and girls' worth can be achieved.[9]

The Cultural Context of Population Issues

Choices and information regarding population issues will inevitably be conditioned by different cultural contexts, and in particular by different belief systems. Indeed, it is the challenge of adult educators world wide to come to terms with those systems and find ways to be sensitive to and to respect those cultures. In this issue of culturally sensitive education, it is important to stress the inter-relationship with pre-testing of educational demands, methods and materials. If adult education is to be culturally sensitive it needs to address issues such as sexuality by working with the community prior to the programmes and determining with them what their needs are and how they would like these to be addressed. An emphasis on respect for people, both individuals and larger communities, ensures in turn a positive response from these. In this sense, education should be seen as an exchange as well as a process. Another important aspect of the cultural context of population

issues is that of the language of sexuality, as distinct from the textbook descriptions of sexuality, whether this be discreet in the case of more traditional cultures, or in a language appropriate to youth culture in contemporary Western society.

However, cultures are not static and may be subject to change and influence. Indeed if girls and women are to achieve anything like equal status with men this has to be the case. For, "the heart of the problem is a cultural tendency to devalue girls and women. Until this is overcome - and education is usually the most effective means to that end - the problem will remain" (UNESCO 1999:27).

The role of NGOs

NGOs have been extremely active in the field of population education, particularly feminist NGOs focusing on women's rights and on health issues for women. The role of NGOs, however, and their relevance in relation to government policy needs to be drawn out and emphasized. NGOs have not only been responsible for lobbying governments and international agencies and bringing about changes in the way these issues are viewed, but have also been responsible for some of the most innovative experiments in the field. NGOs represent the voice of society in a way that governments do not, although their power must always be negotiated and limited precisely because they are non-governmental.

In the following chapters of the book there are various examples which draw on the richness of the experience of the non-governmental approach to population issues. In particular, Mercy Hatendi describes in detail the NGO movement in Zimbabwe, which was initiated as a response to restrictions on women's freedom of movement at night. From this initial protest, which claimed to defend women's freedom to walk unaccompanied in the streets, grew the Women's Action Group, now the country's leading NGO for the promotion of women's

health and legal issues. Involved both in the preparation of innovative educational materials, and programmes, WAG has also introduced both lobbying by NGOs for specific issues and accountability monitoring of public expenditure on health and health education.

Part I of this book addresses the issue of men, masculinities and health from the population perspective. The field of gender and education, although initially focusing almost exclusively on women, as it redressed the balance of previous generations, has moved to a reconsideration of gender relations in terms of the distribution of power between men and women. The argument that men are equally bounded by idealized stereotyping has led to the development of the field of masculinity studies including not only the ideologies of the gay movement (with its questioning of what constitutes legitimate male identities) but also the analysis of heterosexual male identities and how these relate to women's identities. More recently, the need for male involvement in population education has been acknowledged and this has been linked to the new theory and debate on masculinities. New approaches to the involvement of men in non-formal education and the sharing of learning environments with women is part of this trend. In Chapter 1, Benno de Keijzer focuses on the relationship between men, health and violence in Mexico and describes innovative approaches to working with both men and women together on these issues. In Chapter 2, Robert Morell describes the notion of inscrutable masculinity and examines how this can be related to specific health risks, in particular AIDS, domestic violence and reckless behaviour associated with car crashes. In Chapter 3, Imtiaz Kamal provides a description of experiences of male involvement in Pakistan, together with reflections on gender stereotyping by development workers themselves. Finally in

Chapter 4, although not focusing exclusively on the male perspective, *Toufic Osseiran outlines* the cultural context of reproductive health education in the Arab world, including the preference for male children and a description of the gender imaging of the Arab world.

Part II moves to look at population education from a life cycle approach. Following the Cairo conference and the shift from an emphasis on a quantitative focus to a more people-centred approach, the entire life span became the subject of population education and of population policy more broadly. The education of the girl child and the boy child, the phases of adolescence and their meaning in different cultural contexts, the stages of active sexuality and reproduction, and the implications of ageing both from a demographic and a social perspective became central concerns.

In this context, Chapter 5 focuses on the study of adolescents and reproductive health in terms of changing identities and intergenerational conflicts in Mexico by Cristina Fuentes and Clara Sanchez. Chapter 6 presents recent research on intergenerational learning between mothers and their daughters in rural Thailand, carried out by Pimonpan Isarabhakdi and Chanya Sethaput, while in Chapter 7 Raúl Hernández Castellón focuses on the phenomenon of ageing in Cuba, a country sharing demographic characteristics of both industrialized society and the Latin American region.

In Part III, the focus is on policy making for population issues and education. In particular in Chapter 8, Mingdong describes the relation between educational attainment, the use of contraceptives and women´s fertility in China. Chapter 9 contains Greenstreet´s analysis of adult education and population policy in Ghana in terms of women´s empowerment. In Chapter 10, Rodney focuses on the incidence of cancer related to women´s reproductive health in Jamaica, and on the policies required to deal with its prevention. In Chapter 11,

Alfonso Leon describes the relation between reproductive health, education and risk in Cuban society, focusing in particular on AIDS prevention and on female cancers. In the last chapter of this section Torres describes the Cuban government's sex education policy in schools and for young adults.

Part IV explores the role of NGOs in defining and lobbying for population education. Two experiences form the basis for this section. In the first place, in Chapter 13, Hatendi links the case of one Zimbabwean health NGO with political organization by feminists in response to police and government harassment. Lohitkul, on the other hand, describes a successful partnership in the field of population education between government and non-governmental organizations in Thailand.

Many themes in this book overlap in the different chapters, and indeed, given the complexities of the field, it is inevitable that this should be the case. The role of NGOs in creating and challenging the new population education field cuts across the different country experiences, while the backgrounds of violence which affect the lives of men and women within families and communities is another constant. And finally, it is the search for and construction of new gender identities, affecting the whole population that is beginning to take root as an essential component of population education.

The new emphasis on learning throughout life feeds into the debate on population education. This can no longer simply be a question of choosing the best methods or designing the best materials for imparting information on family planning techniques, but is now related to the discussion of the broader issues relating to reproductive choice and family dynamics. Such discussion is not always simple. Whether in the case of men constrained by stereotyped imagery of strong masculinity, or women kept silent by the social contexts that oppress them,

debates regarding sexuality and reproductive choice are marked by strongly divergent points of view. Each religion, each culture, each language, and indeed each gender has a way of dealing with these essentials that differ significantly from one another. Nonetheless, we are all men and women sharing a common world, with a common interest in our children's future.

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[1] *Mid-Decade Report on Education for All.* 1996. UNESCO. Paris.
[2] See *World Education Report.* 1995. UNESCO. Paris.
[3] Education for All Secretariat 1997. *Adult Education in a Polarizing World.* UNESCO. Paris.
[4] United Nations. 1993 *Population, Social Equity and Changing Production Patterns*. Economic Commission for Latin America and the Caribbean. Chile.
[5] See: Fukuyama, F. 1998.
[6] For a complete discussion of reproductive and sexual rights from a population perspective see S. Correa and R. Petchesky 1994.
[7] See Pitanguy, Jacqueline. 1999.
[8] UNFPA. 1997. *State of the World Population.*
[9] UNESCO. 1999. *Education and Population Dynamics. Mobilizing Minds for a Sustainable Future.*

PART I:

MEN, MASCULINITIES AND HEALTH

Chapter 1

Reaching Men for Health and Development

Benno de Keijzer

Introduction

This paper seeks to share part of the experience developed with *Salud y Género*, a Mexican NGO that deals with men and mixed groups in different settings from a gender perspective. *Salud y Género* works in two cities, Xalapa and Queretaro, and is devoted to studying and changing some of the main consequences of gender relations on the health of women and men. Being a mixed group (women and men) has made our work both more interesting and challenging. Our activities are mainly in the areas of adult education and social policy. As an institution we have had the privilege of working with men and women of different sectors (health promoters, community development professionals, adolescents, prison inmates, doctors, nurses, foundation employees and officials, land workers...) in most states of the country. And over the course of the past ten years we have developed a methodology working on issues of masculinity and in particular men's relation to health both mental, reproductive and physical.

Health and Gender

Historically, the gender perspective has emerged from the analysis of the condition of women and their struggles to better it. Much has been learned in the area of health and health rights viewing the condition of women from this perspective. This approach is highly enriched when we include the masculine "side of the story". It grows into a more complete and complex

relational perspective - a real gender perspective. This does not mean believing in all this masculine "story" automatically - it is a point of view we have to take in account in any programme dealing with gender issues. With regard to domestic violence, for example, much important work is being done concerning laws, penalties for aggressors, as well as therapy and assistance to women and children who suffer it in its different forms. This can be combined and enriched with research and programmes that also work by addressing violent men and by working with adolescents and children with a view to prevention.

Through our work we have begun to learn about the socialization process and the conditions leading to male violence not only against women but also among men themselves. In particular, the construction of male subjectivity has to do with:

- the way we handle emotions (especially the suppressed ones like fear or sadness);
- the beliefs we grow up with, concerning our essential "authority" over women and cultural expectations of different "services" we should receive from them;
- the social and cultural validation of violent responses, often seen as a legitimate "correction" of female behaviour.

Thus, understanding men from a gender perspective allows us to find new ways of focusing and preventing this type of problems. In a country like Mexico, where the term "machismo" originated, in a strict sense, there is more than one way of being a man. This means we have to talk about "masculinities", in plural, since being a man has differences according to class, ethnicity, occupation and other variables. In the same context the significance of being a man will change along the life cycle. Though one can find important differences, for instance, due to class or local culture, many characteristics of hegemonic masculinity tend to exist in the different ways most men are socialized. Even if we are socialized in a significantly different

way, this process will develop in opposition or in contrast with this hegemonic model.

Working with men has led us to analyze not only the intergeneric relations (with women) but, just as important, the intrageneric level - the relations among men. The importance of this second level, where fathers, brothers and different types of peers enter, is often invisible. It seems as if masculinity is something that has to be continuously proven along the narrow life path crossing between the risks of seeming feminine on one side and becoming a homosexual on the other.

It is increasingly clear how dominant (hegemonic) masculinity affects the lives of women and children in the areas such as social and domestic violence, reproduction and sexuality. Following Kaufmann's violence triad (1987), this is part of a wider health risk triad that can be seen where the other two sides are the risks to other men and the risks to oneself. In this sense, it is not so clear, at least to men, that the same masculine traits also affect our own lives causing disease and early deaths because of accidents, AIDS, alcohol and other drugs, suicide, violence, lung and prostate cancer, heart problems... No one reflects from this perspective on the fact that men ("the strong sex") in Mexico have 6.5 years less life expectancy than women, a gap that continues to grow (de Keijzer, 1997).

Thus, addressing men's health becomes an important window to analyze and a convenient strategy to work from. We have only to think of the amount of resources and energy invested in these public health problems compared to the efforts directed to their prevention. As men, we have to start questioning many risky attitudes we take up during our socialization process. One of the striking representations men tend to have is in relation to the body: we inhabit "this" body as an object or a machine and use it "up to where it resists", as

many men in Mexico put it. This phrase can be said in relation to sport, work, sex or alcohol abuse.

In this logic, we can consider hegemonic masculinity as one of the main risk factors in many of these public health problems both for women and men. Many health, education and development programmes directed to women in different parts of the world also find that men are an important and often the main obstacle for women and the project's success.

Strategies for Working with Men

There are many questions around the strategies directed to men. Should there really be financing for this? Won't it take away resources from women's projects? How can such a strategy be constructed in the quest for equity? In *Salud y Género* we believe that work with men can and should meet both women and men's needs from a perspective of equity. Women can definitely benefit from a programme working on the abuse of alcohol or strategies aimed at sensitizing men on domestic violence, sexuality and or reproductive issues. A great surprise in many programmes like *ReproSalud* in Peru is the way men get involved, moving from being obstacles to active collaborators. And still, these programmes have to be very careful so this male participation does not limit the empowerment processes of women.

Focusing mainly or exclusively on men's responsibilities as the main strategy may be important, but it is not effective or attractive if the biographies of the men involved are not taken into account. Most men are informed or aware of their obligations, but this does not mean that they are conscious or even willing to take them to a practical level. It needs work at a different level of group participation for men to become conscious of their resistance and the reasons for this.

On the other hand, if we base our work exclusively on information this alone will be as ineffective as in the condom

campaigns or the warnings on alcohol bottles or cigarette cases. There seems to be no fast track in addressing masculinity. We see responsibilities as the arrival point, not the starting point. A good example of this is the research done by Rafael Díaz with the Hispanic gay community in California. The fact that these men are informed about safe sex and even motivated to practice it does not mean they will in fact use it - quite the contrary. Díaz is building a psychocultural framework to understand the complexities and contradictions of this process.

The other extreme: working on the idea of men's rights is menacing to many women struggling for their own rights. This is especially true when sexual and reproductive rights are analyzed. We prefer to talk of men's involvement and participation in sexuality, reproduction and family relations. In this case, men's rights are relational - they have to be thought out in perspective with women's rights and the fact that most of the reproductive process occurs in female bodies.

There is a poorly understood gap between the social construction of male identities and their consequences in terms of violence, sexuality and problems related to reproduction. In this gap there is a level we can call mental health or male subjectivity. It is crucial to address this level to have better results concerning the different consequences (Herrera, et al, 1995). In other words, reaching men has to include:

- working with the emotions and pain involved in our own process. Understanding these emotions can enhance the development of what recently has been conceived as "emotional intelligence" as opposed to the supposedly typical male rational intelligence;
- questioning the ways we establish different types of power relations with women and other men;
- assessing the costs of masculinity on our health and lives of others and the possible gains in changing, not only for women and children, but also for men.

This approach, of course, is slower and more complicated. But the risk is that if we only work with information, men may adopt a new discourse (just like the emperor's new clothes) without really touching their lives. On the other hand, the process has to be gradual so we do not scare away those men who still approach these initiatives with much caution and apprehension. A crucial part of the methodology is that we, as men working with men, have to be subjects of the same process. We can not work with a gender and a mental health perspective on sexuality and reproduction issues without letting those perspectives cross our own lives.

In our contacts with men and women in different programmes we have sensed a mixture of a sense of need, curiosity, fear and resistance among those participating, combined with a considerable pressure by women. We still have to find more creative ways to invite them, since a workshop on "masculinity" or "for men" sends out the most unimaginable messages.

Though women are ambiguous about the possibilities of working with men, nevertheless the majority of them support the initiatives. Most of the men we work with are related to women who participate in health, education or development projects and who are changing. Male interest and/or curiosity are a result of this feminine transition. "We already know, please tell our husbands" is the common phrase. This has led many programmes in Mexico and other countries to open work with men as a way to improve women's situation.

One of the less menacing paths for men is to invite them to share and talk about fathering. Fathering seems to be a convenient issue to start working on with many men - it can lead to their beliefs about authority and negotiation, domestic work, discipline and violence, emotions, reproduction, etc. When we have enough time and openness we make contact and work on our experience of having been children as a way to understand

our attitudes as fathers. This exercise has led to some of the most intense and striking workshop experiences (de Keijzer, 1998).

The Need for Future Action

Though it sometimes might not seem so, we are also human beings. In our work in training we discover again and again that it is possible to come together as men and to share the experience of our lives without competing and without being drunk. This is the little miracle happening in every workshop around our country with the varied scope of men we work with.

If working with adults is important, it is crucial to work with younger men and adolescents in a stage when many representations and practices of masculinity are crystallizing. Even so, in our experience with them, we sometimes have a sense that we are arriving too late - much more work must be done to reach even younger boys from a gender perspective. This means we have to address the school system more intensively including both children and their teachers.

There is much to be done in different areas. We have, for example, to change policies that limit male participation in important moments like presence at birth and in the caring of a new born or a sick child. Most Latin American laws and services are not open for these possibilities. The initiative of Mother and Child Friendly Hospitals by UNICEF has left the father out in a time when he might be extremely sensitive to reflect about the type of life he might be willing to construct with his partner and child.

There is also need for more research on men, in particular:

- understanding the contradictions in men who have been victims or witnesses of violence, alcohol or sexual abuse and who tend to reproduce this in their adult lives;

- the different transitions taking place among men including the ones who are moving toward equity and the ones seeking more traditional ways of relating (Valdés and Olavarría);
- what helps and makes some men change and seek equity in reproductive, sexual and family relations;
- what kind of projects and approaches are having better results in working with men and how they contribute to equity.

We are already moving towards wider social approaches to reach more men with campaigns addressing fatherhood and the prevention of violence towards women. These campaigns have to take in account men's representations and practices, seeking the development of gender empathy in issues around reproduction, sexuality and domestic violence.

All of the points stated above tend to reinforce the idea that equity can and should be sought for from both the female and the male side. As Michelle Borgad (1991) puts it in a book on therapy with men: "This process can be angry, confusing, self-righteous, and painful, but it is not without many moments of exhilaration and promise."

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Chapter 2

Boys, Men and Questions of Masculinity in South Africa

Robert Morrell

"Don't let the fear cut you off from people you care about"[1]

Introduction

South Africa's health and education systems bear the marks of three centuries of colonization. The pattern of health of the country's people reflects strong racial and class bias. Some indicators of national health (provided in Appendix 1) demonstrate how these variables play out. The new ANC government has, since 1994, pledged itself to national transformation, gender equity and racial redress. Health and education have become key policy areas. In health, the new government has moved from a trauma/first world orientation to a preventive/community health approach attempting, in this way, to improve the lives of the poorest people. In education, a similar emphasis is discernible. Funding has been shifted from secondary and tertiary education to primary education and from white, urban privileged schools to those serving impoverished communities. While gender equity has been an issue in these reorientations, a weakness has been the omission of 'masculinity' in the definitions deployed by gender policy makers.

This paper starts off by describing the health of men nationally. It suggests that masculinity is a problem for men, for education and health policy makers and practitioners. With specific respect to two areas of health - AIDS and car crashes - it

demonstrates how masculinity needs to be taken into account. It suggests that a particular form of male gender identity - inscrutable masculinity - is implicated in practices dangerous to health and needs to be addressed. It then examines some recent heartening developments and suggests that these may be a beginning in the creation of alternative masculinities. The title of the paper attempts to capture this development. It borrows a slogan from a local AIDS poster which appealed to sexually active men to become sensitive to AIDS sufferers and, by implication, to be willing to express their own emotions openly. This may be a way of cracking inscrutable masculinity.

Health and Masculinity in South Africa

Historically, the development of health services was divided along the lines of race and provided vastly different facilities to black and white. From patient to professional, the system was racialized. The system was also dominated by male professionals which had adverse effects on female health and gender relations. Western medicine became the dominant mode and was generously provided to white patients. For Africans, the provision of healthcare was meagre and traditional approaches to health continued to rival Western medicine in popularity and efficacy (Bradford, 1991; Burns, 1996; Burns, 1998; Deacon, 1996; Klausen, 1997; Marks, 1994; Shapiro, 1987).

Today, South Africa is a middle-income country when judged by international standards. This means that in GDP terms South Africa is relatively well off. Yet, despite government's commitment to redress, the difficulty of transition and the backlog in the equitable provision of social services means that in real terms there is a shortage of resources in health and education and inequalities persist. Furthermore, as the figures below will demonstrate, the socio-economic forces which produce inequality, still exist. South Africa is, in important respects, an unhealthy country for its people.

A large number of people every year die of "unnatural causes" (16% of all deaths in 1990 were due to non-natural causes (Klugman and Weiner, 1992). It is for this reason that South Africa has a reputation for being an exceptionally violent country. By 1996, according to WHO figures, South Africa had the highest rate of violent death in the world (57 per 100 000 *Sunday Tribune*, 12 May 1996). Yet it is ultimately unhelpful to conclude simply, as Warren Farrell does in his *The Myth of Male Power* (1993), that men are the major casualties of war, the victims of overwork and so on. On two counts it is important to take both issue with and go further than this statement which sets the collective state of health amongst males against that of females. In the first case, masculinity should be distinguished from men - men are involved in high risk situations and jobs because of divisions of labour and gender arrangements which include particular configurations of masculinity by which men accept and/or are interpolated into being tough, brave, strong, etc. Secondly, not all men suffer equal risk or mortality. Breaking down figures into men and women obscures the fact that class and race (and other variables) are very important in determining the gendered nature of health.

In his introduction to a *Men's Health and Illness*, Michael Kimmel identifies, in the US context, certain gender health patterns. Men are nine times more likely than women to die of AIDS, six times more likely to die of lung cancer, five times more likely to die of bronchopulmonic diseases, three times more likely to die in motor accidents and by suicide (Sabo and Gordon, 1995). Kimmel continues:

> Masculinity is among the most significant risk factors associated with men's illness. Men's behaviour both adds to risk of death but also prevents them from doing anything about it, because 'real men don't get sick' and 'real men don't get frightened' and 'real men don't talk about danger and fears'.

These general points about the gendered nature of health are important but they do not, and cannot, capture the realities of the gender of health in South Africa. Some of the patterns identified above are true for South Africa, but others are not, and those that are true need to be broken down into their components to allow the importance of race and class to be revealed.

The specific form which colonialism and capitalism (often called racial capitalism) took in South Africa needs to be taken into account in any assessment of masculinity and health. Put most basically, segregation, and later Apartheid, separated white people from black in the context of an authoritarian social system which legislated discrimination against black people and installed a militarized system which affected the society as a whole.

The strains of this system were felt and manifested in many ways. For most black men, life involved physically demanding and dangerous manual labour (often underground in the mines) and a decreasing area of public authority - initially deprived of the vote, and gradually of rights within the household as well. Young men first attempted to escape and then to challenge the authority of the male patriarch while a significant number of women began to gain economic independence. For many white men, while life was materially comfortable and white collar jobs were the norm, the system in which they grew up was emotionally cold and constraining, filled with rigid hierarchies and notions of national service which made them both obedient and rebellious. South Africa's history and its social institutions set people against one another. While it may be premature, it is possible to suggest that in South Africa another effect of this history was something akin to Wilhelm Reich's authoritarian personality - predisposed to accepting orders and repressing the consequences.[2]

The Importance of Masculinity - Inscrutable Masculinities

Theoretical work on gender in the recent past has produced a revolution in understanding (Connell, 1995). Whereas gender was understood as being synonymous with women and gender development equated with empowering women, it is now understood that gender work involves tackling the relationships and structures that bind women and men to one another and the world. In an important contribution to this debate, a special issue of *Gender & Development* (1997) made this point and spelt out its implications for gender work. Andrea Cornwall writes:

> Old-style feminist theory dealt with them at one stroke: men were classed as the problem, those who stood in the way of positive change. (...) Only by abandoning those attributes which are culturally valued as those associated with masculinity could men reprieve themselves. It is hardly any wonder that many men found this difficult (Cornwall, 1997, 10-11).

In a companion article, Sarah White argues that including men in gender policy and programmes will "broaden and deepen our understanding of power and inequality" (White, 1997, 14). Men should not be regarded as a threat to development, women's empowerment and healthier gender relations. Rather, they should be considered as part of a complex which requires holistic attention. This means taking masculinity - that is the socially constructed gender identities of men - seriously. The social environment in which men operate places constraints on what is possible. As Cornwall, puts it:

> If certain ways of being a man are culturally valued, then asking men to abandon these identities altogether without having anything of value to hold on to is clearly unreasonable. But if men become aware that in their own everyday lives they are already behaving differently in different settings without losing a sense of their own identities, then it may become easier to recognize some of the implications of 'hegemonic masculinity' without feeling attacked or threatened (Cornwall, 1997, 11-12).

In South Africa, feminist thinking has followed closely in the tracks of European feminism. Throughout the 1980s and early 1990s, writing focused on women (for example, Cooper,

Mnguni and Harrison, 1992). In the health field analysis stressed the importance of increasing "women's ability to exercise control over their lives both by gaining access to information and by developing marketable skills" (Klugman and Weiner, 1992, 54). Yet the realization that dealing exclusively with women actually alienated men (see Kenway, 1995) and that empowering women meant little, when gender relations were predicated on male power which could easily nullify feminist advances, has gradually shifted gender thinking (Miles, 1992). A major advance has been the recognition that there are many masculinities and that not all men cleave to the hegemonic masculinity which subordinates women and silences oppositional masculinities. With this understanding, it has become possible for educators consciously to develop alternative understandings of masculinity and to foster gender harmony by working with men and women.

In modern, urban-industrial contexts the shape of these alternative masculinities has been charted in a number of studies (Connell, 1990; Messner, 1997). In South Africa, equivalent organizational developments have occurred and, it can be argued, gender relations are also changing in an organic way, quite apart from conscious moves initiated in the public realm. An additional dimension, however, needs to be considered in South Africa which is a developing country with a subsistence sector still intact even if depleted. Tradition is often invoked by highly conservative movements to justify the *status quo*. Patriarchy is often defended in this way. But it is not necessarily the case that backward looking moves oppress women or that they enshrine oppressive masculinities. In the context of Trinidad, for example, Sampath suggests that features of local masculinity, such as respectability, should be developed and built upon rather than attacked. He argues that if the project is to highlight these traditional values, then current compensatory efforts, like fighting to realize masculinity, might lose their

power or potential and become a less common resort for men who have lost status and who lack jobs proudly to assert their gender (Sampath, 1997).

The potential to work with men and develop alternative masculinities does not deny that a relatively common feature of male gender identities is an absolute unwillingness to communicate feeling. This inscrutability may have its origins in what Michael Kaufman calls the triad of men's violence - an effect of being locked into a psychological drama which society reinforces by not creating social space for the exploration and expression of the pain that underpins aggression and violence or of validating those ways of being, expressed in masculinities, which challenge the inscrutability of hegemonic masculinity (Kaufman, 1987). The context or institution in which inscrutable masculinity develops may be very important. One institutional context is the family. Historically some feminists have stressed the inhibiting or oppressive structure of this unit but in so doing have actually ignored the emotionally supportive role that families can play (Engle, 1997). This was a point made many years ago by Hazel Carby (1982) in the context of black families living in Britain. She argued there that the "evil" of the family was slight as compared to the dangers of racism and that families were strong redoubts which helped black people (men and women alike) to live in a racist environment. If we agree that families are important without tying ourselves to any orthodox understanding of what family might be, it becomes a source of concern to note the decline of the family and the isolation of men.

In South Africa, families are shrinking (extended families are declining, nuclear families are unstable). They seem unable to bear the weight of social changes including the demographic reality that more members of a family unit are out of work than ever before. Families do not appear to be the havens described by Engle and Carby that they may once have been. It is in this

context that it is important to talk about the effects on masculinity of this change. Briefly put, masculinity has become more violent, closed and defensive (see Campbell, 1992). This is not to say that men are not capable any longer of showing emotion, of being peaceable, of living communally, of resolving difficulty constructively, of relating to other people in a friendly way. Rather, it is to say that at moments, often when stress and tension are heightened, they become inscrutable. They contain their own emotions and this prevents them from dealing with their own inadequacies and promotes situations which may turn violent. In this emotional place, the rights claimed by men because they are men become evident: the people who bear the brunt of this are women, other men, children and, of course, the men themselves. In describing this masculine moment as inscrutable masculinity, I want to stress that this description is not fully inclusive or complete. It is a moment (a very disconcerting moment) which dominates at particular times and in particular relationships and may be a dominant component of a particular, hegemonic "masculinity". While the inscrutable form of masculinity may be a general danger to men, it is a particular danger to men who are out of work, without support groups, dependent on crime to survive, scarred by political violence. In South Africa, this group is predominantly African and young. Making a similar point in the context of the US, Robert Staples describes this social group as an "endangered species" because of their unemployment and their high risk to lives of crime, alcohol and drug abuse (Staples, 1995).

The following will give the reader some idea of the importance of race in determining masculinity in South Africa. At birth black males are seven times more likely to die than white males. They are likely to suffer from poverty related diseases, particularly tuberculosis. African men have a life expectancy that is nine years less than for white men (Orkin, 1998, 32). Black (particularly African) men are far less likely to

commit suicide than white men, though the rate amongst African men is rising (Mayekiso, 1996). Because of the close correlation between class and race, black men are far more likely to end up in gaol or as victims of violent crime, than white men. Nationally, they are much more likely to die violent deaths. In a recent Cape Town study it was found that 84% of those who died violently were young black males (*Sunday Times*, 3 December 1995). White men have higher rates of suicide than black men (Lerer et al, 54) and are the major protagonists of family murder/suicide. White men outlive coloured men on average by ten years, but white women outlive their menfolk by seven years (Orkin, 1998, 32). White men in South Africa on average earn three times more than African men (Orkin, 1998, 24). 71% of white men have an education to matriculation level or more. Only 20% of African men have matriculation or more (Orkin, 1998, 27).

AIDS

The AIDS epidemic is affecting South Africa's people seriously and is likely to get worse. The first cases of AIDS in South Africa were reported in 1982 though it was not until 1987 that the first black case was reported. Since that time, its spread amongst Africans (rather than all blacks) has been alarmingly rapid. In 1991, the infection rate was 5%, by 1995 over 20% (Leclerc-Madlala, 1997, 366). It therefore takes less than 24 months for these figures to double. Between 83 and 91% of all HIV positive cases are African (and only 77% of the population is African) (Thomas and Howard, 1998, 96).

Of South Africa's nine provinces, KwaZulu-Natal has the highest infection rate - 1.2 of 1.8 million cases recorded nationally (Leclerc-Madlala, 1997, 363). The disease is spreading most rapidly amongst people between 15 and 30 and

is particularly rife amongst young women and new-born babies (Unicef/NPPHCN, 1997, 7). For each man infected, the rate is 1.37 women (Thomas and Howard, 1998, 96). These figures allow the conclusion to be drawn that AIDS is a feminist issue but if, by this, it were to be understood that the focus of attention should be placed on women, then a mistake would have been made. There are two reasons for stating this: firstly, many men are infected and some, for example, African mine workers, are particularly at risk (Campbell, 1997). Secondly, the way in which HIV is spread involves men and women and it will be argued here that ignoring issues of masculinity will dilute the impact of campaigns.

The disease has already changed world views and gender relations. Leclerc-Madlala reports that for Zulu township youth, HIV infection has come to be accepted as a new and inevitable part of growing up" (Leclerc-Madlala, 1997, 363). "Many are convinced that they are already carrying the virus, while most are satisfied knowing that they may or may not be infected, but either way it "didn't really matter"... (because) ... as one can expect measles as a child, one now expects HIV/AIDS as an adult" (Leclerc-Madlala, 1997, 368). This fatalistic acceptance is compounded by vengeful actions by men who are diagnosed as HIV positive. A 24-year-old informant in a study conducted in a Durban township said: "You know you'll be rejected; you know you're going to die. All you can do is go off and spread it. It's your only hope, knowing that you won't die alone" (Leclerc-Madlala, 1997, 369). Some now believe that a positive HIV diagnosis promotes rape and many health officials no longer make their finding known, even to the infected person (Leclerc-Madlala, 1997, 372). Another horrifying indicator of change is the increase of child rape (90% increase between 1985-90 and 1990-1995). Cases of fathers raping daughters are now relatively common, but were almost unheard of 10 years ago. This is generally put down to the commonly held view that having sex

with a virgin cures AIDS. (Leclerc-Madlala, 1997, 374-5). AIDS has promoted inscrutable masculinity.

Education, health and masculinity coincide powerfully in a consideration of AIDS. Between 35% and 38% of South Africa's total population is under 15 years of age (Thomas and Howard, 1998, 96). Put differently, those most at risk are at school and this is a compelling reason for including 'AIDS education' in the curriculum. Another critical factor is the very high levels of sexual violence in African schools. The decline in the economy and the unseating of youth from positions of political importance has

> left bands of youth roaming the streets, disaffected, hardened by war and violence, and well armed. For many, crime has become a way of life. There has been a proliferation of gangs which specialize in all sorts of criminal activity, including rape. In KwaMashu, Durban's second largest township, a gang called Bhepa Span (Bhepa from a Zulu word for crude sex) walk the streets in the evening looking for girls to rape. They insured their reputation in 1995 by casually entering a local high school and gang-raping the teacher while her pupils looked on. (Leclerc-Madlala, 1997, 37. See also Mokwena, 1991):

An inscrutable and sexually-violent masculinity is possibly the most active agent in spreading AIDS. It is a masculinity which does not allow men to express themselves, their emotions, and to reach out to those that they love. It is a masculinity that suppresses these emotions and conceals them with angry and violent enactments of that repression.

When transferred into the realm of sexuality, the effects of being inscrutable and unfeeling are devastating. In a recent study of relationships between young adults in a black, working class area of Cape Town, it was discovered that 25 of the 26 relationships investigated were characterized by routine violence by the male partner upon the female (Wood and Jewkes, 1997). Apart from national figures (which are often speculative) about rape and domestic violence, we do not know the extent to which these figures represent the true situation, but indications are that

levels of violence in intimate relationships are very high. Frequently, the violence is triggered by the insistence for sex by the male partner. "Boys frequently felt offended when girls failed to respond to their approaches. This is perceived as girls' "snobbishness" - not wanting to mix with poorer boys. Girls are believed to want relationships only with boys or men who are prosperous" (UNICEF/NPPHCN, 1997, 35). The insistence on sex, penetrative sex, is thus made synonymous with being male. For a female to refuse to have sex, is to call into question the male's masculinity. And when this happens, violence frequently results.

Catherine Campbell's work on African migrant mine workers offers some explanation for why men are so insistent on penetrative sex. The masculinity of these men was constructed around two poles - responsibility and pleasure. As an employee of a mine put it: "There are two things to being a man: going underground, and going after women" (Campbell, 1997, 278). "A man was someone who had the responsibility of supporting his family and hence had no choice but to put up with the risks and stresses of working underground. A man was someone who was brave enough to withstand the rigours of the job". Being a man meant working hard so that "our children will not suffer". Machismo was the "other side" of migrant masculinity. This included "repertoires of insatiable sexuality, the need for multiple sexual partners and a manly desire for the pleasure of flesh-to-flesh sexual contact" (Campbell, 1997, 278). Put another way, the demands of work were such that only a dominant relationship with women could assuage its effects. A similar situation pertained to unemployed youth, living under Apartheid. "Love is worth nothing if (there is) no sex" (UNICEF/NPPHCN, 1997, 39).

In examining the causes, it is obviously important to place substantial emphasis on the role of Apartheid (understood to mean a set of historical forces which produced a highly

exploitative and authoritarian social system in South Africa). Its impact on the family has been profound. The best-known feature has been the disruption of family life by migrant labour where African men enter employment for varying periods (but often a year) without seeing their wives and children (Murray, 1981, 102, 112). Another factor has been the decline of the extended family, which is associated with the decline of rural subsistence economies and attendant urbanization. Yet these considerations tend to obscure the importance of endogenous factors. It is not automatic that urbanization and proletarianization will cause or be associated with a decline of affection and an end to intimacy. Explanations for these developments must be additionally sought in the way in which gender identities and relations are negotiated in the context of change. It is here that features of the African patriarchal order have contributed to the emergence of inscrutable masculinities.

Despite the increasing number of female-headed households the idea of a dominant head of household still holds firm. There is an absence of discussion and openness which is aggravated by a gender chauvinism. For example, a young African women in Gauteng said, "If boys make mistakes, the parents will ignore the whole matter. If a girl makes a mistake the issue will be raised for a long time" (UNICEF/NPPHCN, 1997, 21). Another said: "I was not brought up in a family in which I was given the privilege of voicing my problems with my parents or discussing issues related to our health as young people" (Unicef/NPPHCN, 1997, 21). A UNICEF study in 1997 concluded that many or most adolescents do not feel loved in the home environment (UNICEF/NPPHCN, 1997, 21).

There is little talk about sex between parents and children - and children fear beatings if they admit to being sexually active (UNICEF/NPPCHN, 1997, 27). There is very little communication between parents and children. Mothers assume that when girls have boyfriends, they will be engaging in sex and

send them to the clinic for contraception. But there is no talking about this (UNICEF/NPPHCN, 1997, 74).

To compound matters, migrant labour has perpetuated a type of polygamy. The established practice of polygamy, associated with the payment of bride wealth (*lobolo*), exists side by side with less formal sexual relationships. Men accustomed to having or being socially permitted to have more than one wife have continued this practice in an urban, wage-earning setting. But whereas in rural society strictly kept conventions governed the conduct of such relationships, men in the new world of urban life felt able (because they remained the major earners) to have multiple partners in many different, widely separated, places. In at least some instances, this undermined the stability of primary relationships (Spiegel, 1980, 152-3; Manona, 1980, 199-200). A large number of children are born out of wedlock and families have become places in which men do not seek or find emotional support. Furthermore, irresponsible (and often brutal) behaviour by fathers may well have fuelled the callous sexual behaviour of their children (Jones, 1993). The very common phenomenon of pregnancy in schools, for example, is accompanied by boys feeling no responsibility for the pregnancy or its consequences (Masuku, 1998).

In rural areas, youth suspect the increase in promiscuity to be an effect of the breakdown of cultural traditions. The demise, for example, of initiation schools has left a hiatus in teachings and discussions about sexuality (UNICEF/NPPHCN, 1997, 29). The UNICEF report speculates that, "It may be that boys in rural communities are more open to taking responsibility for their own fertility [because they acknowledge]. (...) the loss of traditional practices [which] is partly responsible for the high incidence of teenage pregnancy" (UNICEF/NPPHCN, 1997, 80).

Schools have the potential to provide the kind of environment needed to tackle inscrutable masculinity. Unfortunately, there is little evidence of this currently being the

case. The present curriculum, for example, makes the subject "guidance" (effectively a lesson on counselling) optional and the cut-back in teaching staff has meant that the minimal counselling services provided to schools are declining. This development is despite the fact that the draft policy for Women's Empowerment recommended that:

> School children should receive sex and life skills education to reduce the increasing rates of young women dropping out of school because of teenage pregnancy. Life skills courses should include civic, political and legal education to prepare young women for future leadership roles in society (UNICEF/NPPHCN, 1997, 18).

Those worst hit are the poorly-funded schools providing for the education of black youth. There have been attempts to tackle AIDS in school. Sophia Ngcobo, Deputy Chief Education Specialist (Psychology and Guidance) in KwaZulu-Natal, describes courses that have been run and materials that have been distributed. But she is sanguine - little change has occurred amongst teachers and learners. In a sense, this is not surprising - there is and always has been substantial opposition to 'sex education' (ATTIC, 1995). However, it is not in the schools that the most important changes are occurring. NGOs have been (and remain) leaders in AIDS prevention work and some of them are moving into new terrain - targeting soccer players and township youth (instead of women) in their attempts to prevent the spread of HIV.

AIDS and Masculinity - Local Initiatives

Gethwana Makhaye was a community nurse engaged in rural primary health care in KwaZulu-Natal. This work, in the early 1990s, gradually pushed her into working with AIDS. This work made her realize how inadequate was the provision of counselling for AIDS sufferers and their loved ones. The present capacity of medicine does not include curing AIDS - people who know that they are HIV positive therefore know that they are

going to die. This realization is generally traumatic for them and those close to them. In confronting situations where people did not want to know whether they were HIV positive, Gethwana realized how emotionally repressed people were, how unsympathetic was the climate for empathizing with those afflicted and providing them with support. Her early AIDS work was with women - training them as community workers, giving them money-earning skills by which they could lift themselves from dependence on men. Faced with the naked fact of male power - men making decisions for and over women in many different contexts because they had the money and the hierarchical or structural power so to do - Gethwana has now switched her focus onto soccer players. Soccer is a predominantly black, male sport. It is watched primarily by black men and boys and is played in wide range of formal and informal settings. It is where the black men are, says Gethwana. The project is just in its early phases but already one of the reasons for (or manifestations of) inscrutable masculinity has been made evident to Gethwana.

> For example, take this simple thing. If a woman says no to sex – I'm tired – I don't feel like it. That's a sin, a crime. How can you say as my wife, how can you say to me, that you don't want to have sex now and tonight or today and here. I mean that is very simple. A woman is not supposed to be tired, a woman must always satisfy these men. A woman can't say "I don't want you to do it this way, I'd prefer you to do it this way, because what do you know." I mean I've just had a focus group where I was, like, not really tested but I was trying to formulate the basis for my questionnaire. I was talking to young boys between the ages of 12 and 18 and they said that would be like an insult for a girl to come and say to me this is how I must do it, because I am the one who's doing it – she is not doing anything. So I don't know how to explain it – so it's a one-man show within a relationship, even this communication, even the rights to have more than one sexual partner, I, as a man, I'm supposed to have more than one sexual partner because I need sex like all the time and a woman can't take a rest (Makhaye interview).

Apart from male entitlement (which causes an imperious communication style), Gethwana also found that men were unable to talk about sex between themselves. The fear and inhibitions surrounding the subject have been aggravated by AIDS and now men are collectively in denial. Her project is designed to break down the reserve, to rip off the inscrutable mask, to get men talking to one another so that they can express themselves to their partners. In South Africa, knowledge about contraception, condoms and AIDS alone has not prevented the spread of the disease (Campbell, 1997, 273; Leclerc-Madlala, 1997, 366). Men continue to have unprotected sex even if they know it may result in HIV. In communicative relationships, where partners take equal responsibility for sexual health, the chances of avoiding HIV are much greater (Lipschitz, 1998). The challenge then has to be to build better communication, not in a technical sense, but in an emotional sense.

Another recent initiative (titled "Men as Partners") has been undertaken by the Planned Parenthood Association of South Africa. Responding to what might be an exaggerated claim by the local Minister of Health that 45% of girls would lose their virginity by the age of 14 through rape and the fact that the Department of Health is not putting any energy into working with men (and masculinity), PPASA has developed a programme which targets Zulu-speaking youth under the age of 20. This group suffers agonizing confusion on the issue of sex. Most regard it as an essential activity which affirms their masculinity. Many are very religious. They fear AIDS and want sex with virgins and this leads to violence and guilt. The course has just begun and is designed to get participants to think about what Dennis Bailey, a PPASA official, calls "male formation" (Bailey interview).

A different set of responses which have consciously drawn on "tradition" has emerged in rural settings. Responding apparently to a number of pressures - "out of control youth",

promiscuity, erosion of respect (particularly for elders and men) and rampant HIV infection - the practice of virginity testing has been resurrected. The first initiative was taken in 1993 and since then it has gathered momentum fuelled by local political rivalry (between the ANC and the Inkatha Freedom Party) and vigorous organization by Andile Gumede, one of the chief organizers. The ritual involves young females submitting to public inspection. Women elders, vested with the status to undertake this task, examine them to see if the hymen is intact. Certificates are granted to those who participate. Initially confined to rural areas where nakedness is not an issue, the ritual has now found its way into urban township schools. There is much to be discussed about this initiative, not least its implications for human rights. The ANC Women's League has already challenged the initiative as an infringement of children's rights (Hamilton, 1998). More germane for the purposes of this paper is the fact that it places responsibility for fidelity and the retention of virginity on women. This does not address the issue of male culpability, and also ignores the fact that many sexual liaisons are foisted onto unwilling girls. Yet the possibilities that tradition offers should not be ignored. In Kenya, for example, the persistence of circumcision practices appear to be having a positive influence, slowing down HIV infection. This is because HIV infection rates drop where the instances of sexually transmitted diseases (STDs) are low and circumcision reduces STDs (Gregson et al, 1998, 46). In other third world contexts, traditional ways of healing have also been successfully used - for example, to integrate youth back into society after long periods of violence have left them marginalized (Large, 1997, 28).

Road Accidents, Masculinity and Education

A gender examination of car crashes[3] has recently revealed a number of important features in this key area of health. In a first world context, for example, Waldron has shown that more men

are killed in car accidents. She puts it down to the fact that more men are likely to be drunk while driving, more are likely to take risks and more are likely to be in physically dangerous jobs (Waldron, 1995). South Africa has the unenviable record of one of the highest road fatality figures in the world.[4] Nobody in this country has yet attempted systematically to determine why this is the case, but a gender study of the situation would undoubtedly shed a lot of light on the problem.

76% of all motor accidents occur in three of South Africa's nine provinces, including KwaZulu-Natal. In 1996, 10 000 people were killed, 50 000 seriously injured. 40% were pedestrians. In a three month period at the end of 1997, the racial breakdown of fatalities was 67% African, 14% white, 14% coloured and 3% Asian. 61% of white fatalities were vehicle drivers, whereas 6% were pedestrians. For Africans, the equivalent percentages were 14 % drivers and 40% passengers - a stark indication of how Apartheid has left its mark on deaths on the road.

Far more men drive motor vehicles than women although exact figures are not available. It is thus not surprising to find that men dominate the fatalities.[5] More seriously, since it is drivers who make the errors which cause accidents, they (men) must be held largely responsible for the very high fatality rates. In order to understand this, we need to understand much more about why men drink, drive aggressively, take risks, do not heed warnings, ignore instructions and road traffic signs, etc.

Arrive Alive is a campaign launched to deal with this problem. Sbu Ndebele, Minister of Transport of KwaZulu-Natal and Provincial Chairperson of the ANC, engages in educational activities in the campaign. He toured the rural areas giving talks, meeting people, unveiling tombstones, raising awareness, reaching out. A play which brings home the terrible emotional, financial and social consequences of injury is currently touring the province. It has drawn thousands and, in conjunction with a

public campaign to donate wheelchairs to victims, has kept the profile of road safety high. Sbu has also named, and condemned, the forms of road behaviour such as aggressive driving (leading to road rage and risk taking) and speeding which are attendant features of hegemonic masculinity (*The Saturday Paper*, 11 April 1998).

Making the Personal Political

In the two cases of Gethwana Makhaye and Sbu Ndebele cited above, the inspiration and success of their respective initiatives have come from deep personal encounters. Death and the prospect of losing people close to one can have this effect. Gethwana was confronted by the realization that her brother was HIV positive. In 1990, her sister in law had died of "liver cancer". Four years later her widowed brother was diagnosed HIV positive. In dealing with her brother and family she came to a new understanding of AIDS. Not only has she realized how important it is to work with men, but she has grasped how difficult it is emotionally for men to deal with the horrific truth of AIDS.

The success of Sbu Ndebele's campaigns has had everything to do with his personal tragedies. These began when he was about to begin a ten-year prison sentence for his part in attempting to overthrow Apartheid. In that dark period it was the death of his mother and father, as much as the torture and isolation that he endured, that touched him deeply. He grew up in a secure family environment. His mother had been his childhood confidante. Detained in 1976 and held *incommunicado* under the terms of South African security laws, he longed to see her in the brief moments when the law brought him from his detention cell to the court. It was here, in an cruelly impersonal, official letter, that he found out that she had died. Sbu's father taught him from an early age the importance of honesty and community service. Sitting out his prison sentence

on Robben Island, he longed to see his father with whom he was steadily developing a close relationship. In 1981, the visit was arranged. Delayed by a month to accommodate another of Sbu's family, it was destined never to take place. In the intervening period, Sbu's father died.

In 1994, two weeks before the ANC swept to victory in the polls in the first democratic election, Sbu's eldest son, Nhlakanipho, aged 24, was killed in a car crash. Sbu had been separated from his son for many years but since his release from prison in 1987, he had moved from being an acquaintance to father to close friend. Together they attended meetings, talked long into the night, shared their dreams and hopes. Sbu admits that to this day he has not dealt with the full extent of the loss. Tears come to his eyes at the mention of his loved ones.

The success of road safety campaigns in KwaZulu-Natal have to be understood in terms of Sbu's personal loss and the conviction and compassion that it has generated in him. At the public closing of his *Siyabakhumbula* campaign, his sister said: "It took a lot for him to share his grief, especially since he never really came to terms with Nhlaka's death". Sbu's grief has informed his campaign: "*Siyabamkhumbula* is so close to his heart and he has driven it so fervently, he felt the need to show the public its true importance" (*The Sunday Tribune*, 31 August 1997).

The willingness of Sbu Ndebele publicly to share his grief (and thus break down the inscrutable face of masculinity presented stoically at times of loss) and to talk about loss makes him an easily recognised and loved minister in the region. He has shown the benign and gentle possibilities of being a man that may result from dealing with the shock of loss. Both he and Gethwana have converted their personal losses into passionate (political) campaigns and both with marked success.

Conclusion

People get AIDS even though they know that they should use condoms. People die in car crashes even though they know that they should not drink and drive, should wear a seat belt and should not speed. If this teaches us anything it is that there are severe limits to the transmission model of education, which focuses only on the transfer of knowledge.

It has been argued in this article that men are deeply implicated in issues of health. It has further been suggested that a particular construction of masculinity that produces inscrutability is a cause, possibly a major cause, of ill health. Not just for the men who will not acknowledge their feelings, but also for the people onto whom these feelings are projected or upon whom these feelings are taken out. An education is needed which takes emotion seriously, which helps men (and boys) to develop an emotional vocabulary. Only in this way will men lose their fear of reaching out to the people that they love.

Appendix 1

This provides some indication of the nation's health. Where possible, figures have been disaggregated by race and gender. The way in which figures are generated generally makes it very difficult to factor in class.

Rape: In 1996, there were 119.5 reported rapes per 100 000 (Orkin, 1998, 36). In a population of just under 40 million it was estimated that in 1995 one million women were raped (Shifman, Madlala-Routledge and Smith, 1997, 25).

Suicide: 7% of all non-natural deaths in Cape Town between 1993 and 1994 were by suicide. White SA average of 20/100 000 exceeds the US baseline of 13/100 000 (Lerer et al, 1995, 54). For Africans, the rate is well below the US baseline but is rising (Mayekiso, 1995). White men are four times more likely to die by suicide than women and African men nine times more likely to die by suicide than African women.

Family Murder: An exclusively white (predominantly Afrikaner) phenomenon (Graser, 1992).

Prison population: 146 000 (August 1998); 3% female, 98% Black, 1% White. Over one third are under 25 years. [Amanda Diesel, Prisons Research Project, Study of Violence and Reconciliation, Johannesburg, pers com (9 September 1998)].

Life expectancy: Women can expect to live 6-7 years longer than men [White women have the highest life expectancy (76 years) compared with Coloured women's expectancy of 65 years). Coloured men have the lowest life expectancy (59, compared to white men, the highest at 69 year], (Orkin, 1998, 32).

Infant mortality: For 1990 (the most recent figures) there were 54.7 deaths per 1 000 live births (African), 36.3/1 000 (Coloured), 9.9 (Asian), 7.3 (white) [Dr T Govender, Community Health Registrar, Medical School, University of Natal (telephonic interview, 17 Sept 1998)].

Tuberculosis: In 1990, between 10 and 14 million people (the huge majority being black) were infected. This was over 25% of the population. The highest rates recorded are amongst the exclusively black mine labour force (Klugman and Weiner, 1992, 9; Campbell, 1997, 277).

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[1] The full text for the quote in this title is, "Don't let the fear of Aids cut you off from people you care about". It is taken from a 1997 poster put out by the National Progressive Primary Health Care Network and was given to me by Gethwana Makhaye who worked for this organization. In the poster, the man who stands next to Nelson Mandela is Alfred Ntimba, who was HIV positive at the time. He agreed to help in the campaign because he wanted to do something to help. He has since died.

[2] For a gendered discussion of this in the context of gender theory, see Connell, 1995, 17-18. For an example of what such a personality might 'look like' in South Africa, see the biography of state policeman and assassin, Eugene de Kock (de Kock, 1998).

[3] Sbu Ndebele, Minister of Transport in KwaZulu-Natal, insists on using the term 'car crash' to draw attention to the agency of drivers. The more usual term, 'road accident' implies that road fatalities are a result of coincidence or misfortune.

[4] Many measures are provided and contested. A 1996 study placed South Africa as 17th on a list of 20 countries who had the world's worst road accident rates (*The Sunday Times*, 29 September 1996).

[5] From 1 October to 31 December 1997, 66% of road accident fatalities were male - if you halve the number of people whose gender is not given (7%) then you have a figure very close to 70%. Of the total percentage of people killed in car accidents in the year, 1996, 28% were drivers (and just below 90% of these were men).

Chapter 3

Educating Men to Participate in Reproductive Health Programmes

Imtiaz Kamal

Introduction

This paper describes the experience of involving men in reproductive health education in Pakistan. Despite initial scepticism, as this paper shows, men are very open to information on family planning and contraceptive use, if this is done in a culturally sensitive way.

In the 1980s, the contraceptive prevalence rate (CPR) of Pakistan was 7.6% for modern methods and 9.1% for all methods (Contraceptive Survey of Pakistan 1984-1985). By 1990-91 it had reached 9% for modern methods and 12% for all methods (DHS 1990-91). Even though Pakistan had one of the oldest population programmes in South Asia, this was evidently not having sufficient impact.

Almost all family planning projects and programmes focused on women. Although it was commonly held that Pakistani men were not very interested in matters related to fertility or its regulating mechanisms, this has not been substantiated by research (Miller, 1998). Similarly, there is no evidence to support the widespread belief that Pakistani men want to have a large number of children. Nevertheless, the men's negative or passive attitude was among the main reasons often cited for the low CPR and for not having many

projects or programmes involving men. One such scheme, launched by the government in 1970, was never fully implemented. Yet the use of condoms is certainly not a new form of contraception in Pakistan and the withdrawal method of contraception is one of the oldest methods to have been used by Muslim men since the time of the Holy Prophet Mohammad (Omran,1992). It is also worth noting that in recent years much has been written about contraceptive usage by the Pakistani male (Aqil,1997, Douthwaite,1997, Kamal and Khan,1995).

Promoting Male Involvement

In 1985, Pathfinder International, a US-based NGO focusing on population-related activities, established an office in Karachi, Pakistan. Following the parent organization's philosophy of using innovative approaches for promoting the norm of the small family, the team in Pakistan started identifying target groups and, as a result, plans were drawn up for a scheme that would focus specifically on involving men in family planning activities.

The success of the idea, however, depended on finding organized and well-respected male groups capable of working successfully at a local, grassroots level. This search eventually led to two very interesting groups. One was a group of tribal men in the Gilgit valley in the Himalayan mountain region in the north of Pakistan. These men had been trained as an experimental category of basic health workers, called Health Guards, somewhat on the lines of the barefoot doctors of China. Although their training had never been put to much use and despite the fact that they were not an organized group, they had the potential for being able to work under the direction of an organization, a role the Family Planning Association of Pakistan had agreed to accept. The second group was

a well established NGO in Mardan, in the north-west of Pakistan, fairly close to the Afghan border. Called the "Urban Community Development Council", its basic interest was in the area of health and skills development, and it had an exclusively male membership.

Gilgit is a part of the federally administered Northern Areas which are surrounded by the mountains of Karakuram, Hindu Kush, Himalayas and Pamir. According to the 1981 census, it had a population of 575 000. In this male dominated society, women are mostly illiterate and marry young. The fertility rate was high. At the start of the project, the average family size was 7.1 persons and the CPR was almost zero. The overall literacy rate was about 15%. Both Sunni and Shia religious sects are found in this area. The development of these areas has been very slow due to very difficult terrain and consequent high costs involved.

Mardan is a part of the NorthWestern Frontier Province (NWFP), one of the four provinces of Pakistan bordering Afghanistan. The population of Mardan is largely Pathan, one of the largest ethnic groups in the world and inhabiting both the NWFP and Afghanistan. The Pathans are mainly Sunni Muslims and are known as warriors and fierce protectors of their land and women as well as their honour. Their warlike practices are changing, but at a much slower rate than some of their other traditional practices and attitudes. Female literacy is low due to factors such as the limited mobility of the girls and an extreme shortage of girls' schools and female teachers. Girls were married off early from the age of 15. The fertility rate was 6.6 and the CPR was about 8%.

The tribal men of the Gilgit valley and the Pathans of Mardan were, by reputation, an intimidating population. Both Gilgit and Mardan were supposed to be years behind Karachi in terms of gender equity and known to be orthodox and conservative. Doubts

were expressed about whether it would even be possible for a woman (the project coordinator) to approach these groups, not only to talk about contraception but also to ask them to be active participants by training as promoters of family planning. However, as the health guards had some background knowledge of health and the treatment of minor ailments, etc., and had worked with their communities, their re-entry into the community was expected to be somewhat easier. The project initiated in Gilgit for this reason in 1987 and one year later took shape in Mardan.

Despite initial concerns, the idea of learning about family planning and then spreading the message in the communities through its menfolk did not meet with any resistance at all. The only fear expressed was that of opposition from certain religious groups. The first meetings with both these groups, however, were a classic example of how even educated groups, and in particular health professionals, can make erroneous assumptions. In fact, the men were quite willing to ask questions and discuss their feelings openly, even asking for demonstrations of the use of different family planning methods.

The Agencies Involved

In the early fifties the Family Planning Association of Pakistan (FPAP) pioneered the family planning movement in Pakistan long before there were any government programmes. Its headquarters are in Lahore. It has 55 000 members, 5 zonal offices and 24 field offices. Each project is overseen through a local work unit of 25 members, of which there are 160 scattered all over the country. FPAP is an affiliate of the International Planned Parenthood Federation from which it receives a large part of its financial support. The FPAP had a long association with the founder of

Pathfinder International and with its Pakistani Country Representative and so there was a basis of mutual respect and understanding.

The Urban Community Development Council (UCDC) in Mardan started out in 1968 as an extended arm of the government's work for community development. Subsequently, it became an NGO and started receiving an annual government grant. In 1984, when the NGO Co-ordinating Council for family planning activities was formed, UCDC received funding for specific projects. The main objective was the provision of contraceptives through very modest service outlets. The services provided were basically for women and a certain degree of desensitization regarding family planning had taken place already within the community.

The 200-strong, all-male membership of UCDC comprised reputable citizens from all walks of life, including religious leaders, teachers, engineers, businessmen, shopkeepers and farmers, etc. Because of the many interest groups they represent, they were able to provide valuable links to various sectors of Mardan society.

The Projects for Male Involvement

Both the project in Gilgit and the one in Marden were similar in design. Men were to function as field workers in the following ways: case finding; referrals; service delivery (i.e. providing contraceptives on the doorsteps, as trained and authorized personnel); health education about sexually transmitted diseases; providing a follow-up service to deal with any problems and making referrals in those situations they could not handle themselves; and recording and reporting on their work.

The field workers were grouped in teams of five, with one acting as the team leader. The plan was for the different teams and

the team leaders to maintain contact with each other and for each team member to be responsible for a certain number of families or contacts. Although the teams were to meet regularly, meetings in fact took place more often in Mardan than in Gilgit because of the difficult terrain there. A project committee was responsible for the general management of the project. Area Supervisors co-ordinated for a certain number of teams and each project had the technical support of one or two project advisors who assisted with training and helped to solve any problems that arose. Initial and refresher training was a very important component of the project activities. The curriculum was developed in consultation with the grantee organizations, modifications being made as and when necessary.

Training was provided to all participants and the topics covered included conception and contraception (as a shared responsibility); counselling; the advantages of spaced pregnancies; methods of contraception, their mode of action, contra-indications, side effects and application; talking about family planning; Islam and family planning; the provision of community-based family planning services; referrals for services; sexually-transmitted diseases; the importance of recording and reporting; and the population programme in Pakistan. Training was conducted by doctors, nurses and sociologists. An official from the Department of Population often came to talk about the population programme in Pakistan and project managers conducted a session on the administrative aspects of their responsibilities.

Since the health guards in Gilgit were already trained as primary healthcare workers, and were known to the community as such, it was logical that their image as healthcare providers be maintained and family planning added to that role. They were each provided with kit containing basic drugs for minor ailments, to be

sold at cost price, but after that they were expected to replenish their own supplies. However, this plan was not successful because they were working in their own communities where it was regarded in their culture as an insult to charge 5 cents for two tablets of aspirin or indeed to accept such a small sum in payment, particularly when it was known that the kit had been provided free. So, once the drugs were used up, the kit remained empty apart from the supplies of contraceptives and information, education and communication material. If the community had been briefed beforehand that the health guards had to contribute towards the replenishment of the medical supplies, this might not have happened. In a way, the kits served a useful purpose because people started relating them with contraceptives and so began to regard family planning as part of the health services. This also proved to be another valuable lesson, for initially there had been fears that the field workers might start making a profit by charging more than the cost price. IEC activities included simple visual materials, posters, counselling and the screening of health-related films, although some recreational films were also shown at the same time to attract crowds. More than 50 000 people were reported to have attended the film shows.

After a slow start in Gilgit the project proved very successful. The cost per couple per year of protection (CYP) was extremely low but unfortunately, the project had to be terminated at the end of June 1993 due to the withdrawal of USAID financial assistance to Pakistan for political reasons. The available information is shown in Table 1.

At the request of the male educators, 40 women, mostly TBAs, were also trained as female community educators. This provided better access to women in their homes once the approval of their menfolk had been gained by the male community educators.

Furthermore, religious leaders who were willing to support family planning by imparting their knowledge of Islamic religious writings were also involved. Four of them agreed to work as community educators. Once they were trained, they functioned very successfully. In Marden the project surpassed the set objectives.

Based on the quarterly reports and a survey, the CPR in the project area reached 31%. Considering the great difficulties, this was no mean achievement. Educating men about family planning and involving them had paid off.

Conclusion

There were few discouraging problems and few disappointments in these projects to involve men more visibly. There was only mild resistance from certain religious groups in Gilgit and Mardan. In Gilgit, the Zonal Director played an admirable role in satisfying the queries of some of the religious leaders. In Mardan, the Project Director identified four religious leaders who spoke positively about the responsibilities of parenthood. They also received training as community educators. This sensitivity to local beliefs was crucial to the success of the projects and let us to the conclusion that although a conservative society may be a challenge to planners and providers, it is not an obstacle to delivering high-quality family planning services. At the same time, it showed that the establishment of supportive community networks ensures greater programme stability and success, and avoids duplication of efforts.

In a family planning project designed to increase male participation, the role of female doctors, educators and clients must be carefully evaluated. As the results showed, the integration of female community educators, health visitors and doctors in the Mardan Project increased the project's achievements and

community acceptance. An assessment of gender roles in project settings should therefore be used to plan the strategy, scope, and staffing of the family planning activities. Finally, the inclusion of religious leaders at both the planning and implementation stages helps reduce potential opposition to the project and the level of cultural reluctance to accept family planning.

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Tables

Table 1: New acceptors by method, 1987-1993. CBS Project Northern Areas

Method	*1987*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993***
Condoms	1204	1080	1041	1020	1109	1222	836
	(23.5)	(15.4)	(24.4)	(19.9)	(20.2)	(23)	(22.8)
Pills	2994	4660	2287	2716	2670	2634	1739
	(58.5)	(66.4)	(53.6)	(53.1)	(48.5)	(49.6)	(47.5)
Spermicidal	-	-	425	14	23	18	6
			(0.6)	(0.3)	(0.4)	(0.4)	(0.2)
Injections	760	1159	715	1017	1113	855	539
	(14.9)	(16.5)	(16.8)	(19.9)	(20.2)	(16.1)	(14.7)
IUD	47	33	66	246	326	468	343
	(1.1)	(0.5)	(1.5)	(4.8)	(5.9)	(8.8)	(9.4)
Sterilization	112	82	131	102	259	112	196
	(2.2)	(1.2)	(3.1)	(2.0)	(4.7)	(2.1)	(5.4)

* Figures in brackets show % for the method for the year.

** Figures are up to mid-1993.

Chapter 4

Cultural Aspects of Reproductive Health Education in the Arab World

Toufic Osseiran

Introduction

Culture is a comprehensive concept, involving more than learning. Religion, traditions and beliefs are all components of it, some of which are inherited while others are newly acquired. Sometimes these are practised by the people regardless of their convictions, sometimes they are subjected to exaggeration, become idolized and cannot be changed. The urban changes the world is witnessing today are being reflected in many cultural patterns, in ways that differ from continent to continent and even within the same continent. However, the technological developments in communication have exposed the inhabitants of the whole world to a global view. Cultural aspects of any country are transmitted, without restriction, to all countries via the media and communication channels and can be copied, accepted, rejected or modified. Although developments are taking place whose validity we cannot be certain of, we can assume that once they are accepted they become familiar, are practised and become part of what we term "acquired culture". Some of these developments are closely related to issues of reproductive health, such as motherhood outside marriage, abortion, family planning and sexual health among others.

So as not to get lost in the cultural maze, I intend to concentrate here on the cultural values related to the following issues, either discussing them from the Arabic perspective or,

where this is not possible, restricting myself to the Lebanese view:

- Reproduction
- Giving birth to a male child
- The attitude to a large family
- Society's view of women
- Women and work
- Polygamy and divorce
- Sex

The Arab World

The Arab world consists of 22 countries, representing a unique group of nations who share language, traditions and habits as well as several demographic, social and health characteristics. Although each country is an independent state, they all consider themselves to be part of the whole Arab Nation. Arabic thought is characterized by adherence to the past and optimism about creating a better future. The truth of this is apparent when we examine some of the statements contained in the "Second Amman Declaration on Population and Development in the Arab World" which summarized the discussions and studies of the Arab Population Conference that was held in Amman in 1993 in preparation for the International Conference on Population and Development 1994. All the Arab countries were represented at the Amman conference and all unanimously approved the final resolutions and declaration. The second clause of this declaration stated that: "The family is the basic unit of society and it is therefore necessary to create all the appropriate conditions needed to preserve its integrity, raise its standard of living, protect its values and cohesion and provide its members with opportunities for a decent life".

Here, the "protect its values and cohesion" principle is a crucial issue which needs discussion for this clause did not specify the concept of these values. However, it was assumed

that they related to legal marriage, legitimate children, and the traditional roles of women and men within the family.

In the third clause some 'liberal tendencies' were apparent however: "Women, like men, play a crucial role in society. They do so not only as mothers but also as essential factors in resource management, economic activity and national development. Development cannot be realized without ensuring women's participation therein, improving women's quality of life in all its aspects and securing the economic, social, educational, cultural, psychological and health conditions needed to enable them to play their role fully as citizens".

Thus, this clause is very important as it carries with it certain major indications. It no longer restricts the view of woman to her important motherhood role but now encompasses other considerations about her value to society. It proves that society's view of the role of the woman is changing: although motherhood remains a priority: it is not the only role a woman can play. But whether this is enough, or whether different cultural attitudes towards the role of women within the family and society should be established, is the question that arises.

In a logical sequence to the declared principles, the 23rd. objective stated that: "To further sound religious orientations and understanding of population issues in general, and the spacing of births in particular... ". This objective was then followed in recommendation 57 by the statement: "Distinction should be made between mistaken social ideas and the accurate understanding of religion".

From the foregoing, it may be concluded that there is confusion between 'religious concepts' and 'social ideas' for if it is the social beliefs that are wrong, why is religion being blamed for issues that do not relate to it? This is what prompts the need to stress the accurate understanding of religious concepts in relation to reproductive health, and especially to spacing out the births of children.

Reproduction

On examining the value given to producing children by the family and society, we find that Arab society is one that gives priority to, and places importance on, reproduction. The dominating cultures, especially in Moslem communities, find it normal for a man to remarry if his wife is barren, or if she does not conceive quickly for no apparent reason. As for Christian communities, they deal with this issue in a less emotional fashion, as adoption is both allowed and accepted, so the problem of infertility becomes less pressing. Fertility has a social value, as it is used to measure the value of the man on the one hand and the value of the woman on the other. This probably leads to an increase in the number of births with age, irrespective of the possible risks involved.

The surveys carried out by the Arab League, and funded by several Arab and international organizations, to study the health status of mothers and infants, showed that between 1996 and 1998 the average number of living children per woman was as it can be seen in Table 1.

There are two important points to be noted from these statistics: firstly, that there are a high number of live children for every woman in most of the Arab countries, with the exception of Qatar and Lebanon and, secondly, there are significant differences between the Arab countries. This leads us to examine the special cultural dimensions of each individual country.

Although there are many common cultural characteristics, the differences are significant. For example, if we compare Jordan and Yemen or Algeria and Mauritania, it is evident that there are differences in the extent of the progress being made to reduce the number of children being born even in countries belonging to similar regions. These differences are related to several factors. As one of these factors is education, it demonstrates that education does have an effect on population

growth. There is also a relationship between the high average of births per woman and the speed at which a population doubles, as can be seen in Table 2.

It is apparent that 52.6% of the countries double their populations in less than 22 years, 15.8% in 23 to 30 years but that 31.6% require more than 30 years to do so. Where economic resources are limited, the increase in the population puts pressure on the infrastructure of the country and even of the region. This does not apply to the Gulf countries, although they lack specialized human resources.

These statistics imply that there is a need for educational work to be carried out directed at women, their outlooks and beliefs; at men, their outlooks and attitudes; and to society in general to correct the erroneous interpretations of religious texts. As a result of their efforts at enlightenment, fourteen Arab countries have been able to include family planning components in their programmes of reproductive health (Report to Escwa. Faour, M.1998).

The Male Child

The importance placed on giving birth to a male child accounts for the trend to keep on having children until a son is born. It is a known and accepted attitude which does not cause any embarrassment and which dates back to pre-Islamic times when burying alive a newborn girl was common until the Koran forbade the practice.

In a study of the attitudes of men to family planning conducted by the Lebanese Family Planning Association (LFPA) in 1987 (possibly the only one ever to have been carried out in the Arab world), men were asked about their preference for sons or daughters. This revealed that only 0.7% of the men said that they wanted more girls than boys.

In whichever Arab country this question had been asked, the statistics would probably have been the same, or possibly even

higher in the case of those wanting more boys than girls. One personal experience of a woman who gave birth to a boy illustrates this attitude. This boy child was her first child and she received lots of precious and expensive presents from her husband's family. Although, when she asked, they denied that the reason for this generosity was the fact that the baby was a boy, this denial did not reflect the reality of the situation, for people are driven by their emotions when it comes to the birth of a boy.

However, it is not just men but women, too, who need to be made aware of the issues involved for the difficulties encountered in helping a mother accept her baby daughter and develop a positive attitude towards her exceed those we face with men. The birth of a son becomes an obsession for the woman who is late to give birth or who delivers a girl. She is constantly in fear that her husband will leave her and take another wife. Any good intentions of spacing out pregnancies are also forgotten for this woman is in a race with time to get a son.

The Attitude to a Large Family

The importance of fertility in the Arab culture and the actual high fertility rates and average number of births in the Arab world mean that there is a great tendency for larger families, as it is shown in Table 1. Furthermore, financial difficulties or poor living conditions appear to have little effect on this. In addition, research has shown that there is a difference in the average family size between the rural and urban societies. In some Arab countries, this difference reached 100%. This phenomenon may be due to the tribal mentality, which dictates a specific behaviour for men and defines a low status for women.

Society's View of Woman

The declaration at the close of the Amman conference in 1993, which is very relevant to this most important issue, reiterates (in Resolution 58) the view that "woman, like men, play a crucial role in society....". It continues: "As woman's role in development, and the effect she has on the demographic behaviour, age of marriage, fertility, and the percentage of child and mother mortality, is very important, the improvement of the status of women, through population strategies and programmes, should be a goal in the overall national development plans".

Here the focus is on several reproductive health elements, such as the age of marriage, fertility, infant and other mortality, all of which are related to the role of woman and its effect on demographic behaviour. There is also the call for a re-evaluation of the way women are regarded both by themselves, by men and by the society in which they live.

Problems in the area of reproductive health are essentially the result of the less than optimal situation of women in the family and society. It may even be said that the negative attitudes towards reproductive/sexual health and family planning have backgrounds closely related to the women's issues such as the right to determine the time of conception, the number of children and intervals between births. In turn these are related to the lack of women´s empowerment due in part to both low education and illiteracy.

Table 3 shows the percentage of illiteracy for men and women over the age of 15. It not only indicates the high level of illiteracy in general among Arab countries but also shows that there is a far higher percentage of illiterate women than men, in fact, in Jordan, Libya and Syria it is three times higher and in Lebanon it is double.

Illiteracy among women is a major handicap that prevents women from improving their condition. However, programmes that help fight illiteracy, such as that copied from Cuba and

conducted in South Yemen before its union with the North and which was awarded the UNESCO prize, could be repeated all over the Arab world. This would positively influence the status of women and, as a result, enhance the prospects for a general improvement in health, and reproductive health in particular.

Women and Work

The level of illiteracy also makes it more difficult for women to compete in the labour market. Studies in all Arab countries have shown that the percentage of working women does not exceed 25%. This fact is also related to social concepts, especially those of religious leaders, which do not encourage women to work. Some leaders who are less fanatic differentiate between married and unmarried women: unmarried women being allowed to work, while the married ones are discouraged. Where work is available, preference tends to be given to the males, based on the traditional cultural view of man as the provider. If women's participation in the workforce could be increased, however, not only would this aid national development but also improve the decision-making power of women in family matters.

Polygamy and Divorce

Two issues which are of special concern to Arab women are polygamy and divorce although the first, being directly related to a religious tenet, is difficult to challenge. Tunis is the only Arab country that has forbidden polygamy, but it could not stop divorce. In fact, the rate of divorce increased when polygamy was forbidden. As a direct result of polygamy and divorce, the average woman regards herself as a human being only if she marries and produces children. She is attached to her role as a mother regardless of any risk to her health. For her, dying while giving birth is the same as "dying" from desertion or divorce. Furthermore, if her husband remarries and his second wife gives

birth to a male child, then she will live in a state of negligence and contempt that affects the very core of her being.

These are the very real and true feelings of women who have to accept their husbands taking another wife. Even though the Koran refers to polygamy as being unfair and something to be avoided it was not directly prohibited. Although in Lebanon, polygamy does not exceed 1%, in other Arab countries the percentages are believed to be high, especially in rural areas. Divorce is also decreasing, but even though the prophet Muhammad condemned it, it is still practised. Lebanon again is at the low end of the divorce table with a divorce rate not exceeding 3-4%.

What is the relation between divorce and reproductive health? And where do they meet? When a woman thinks of stopping at one or two children or of spacing out her pregnancies, she hesitates. She believes that her husband will get upset, and therefore she does not discuss the matter with him. In that fearful attitude, she takes the unwise decision, and silently suffers the consequences. This is the stark reality. Yet studies in several Arab countries on the use of contraceptives have shown a higher acceptance rate among men compared with women.

These cultural attitudes will not change easily or soon. The reason is that they are rooted in deep religious beliefs related to codes dictated by holy books. It is a change that may only come with advancing knowledge and technology. But, we can reduce the effects of this cultural tendency by separating reproductive health from the other issues of polygamy and divorce. The only way this can happen is by intensifying efforts to educate women.

Sex

Sex is a taboo subject, perhaps the most difficult component of the whole cultural equation and sexual behaviour is the prime moral criterion within the bounds of family and society. Any faults within its domain have severe and dangerous

repercussions. Erroneous concepts or misunderstandings about sex result in: preference being given to males; discrimination against women; women not being permitted to work outside the house; co-education being ruled out; divorce and polygamy. It can also affect the age of marriage and the age difference at marriage.

The issue of sex was the most difficult that faced the organizers of the ICPD conference. It took many discussions and arguments, especially when defining reproductive health, as for example in the proposed use of the term "couples and individuals". In the Islamic culture, which includes Christians of the Arab World, sex practices are not accepted outside marriage. Nevertheless, it may be a cause of early marriage, which in turn may lead to health problems for the mother and baby related to the risk of early motherhood. However, any change in this area will probably not come for a long time. Even the term "sexual health" is still unacceptable. So it is evident that sexual health, and indeed any issue related to the subject of sex, should be treated very delicately because of the violent opposition to any changes. However, in spite of this discouragement, some advances are being made at both governmental and non-governmental levels. The efforts of family planning associations, although limited, are realizing success in education and enlightenment that will eventually break down the barriers and penetrate old concepts, especially in regard to the age of marriage and an increasing concern with reproductive health.

Conclusion:

As we have tried to show, the Arab world, while displaying many common characteristics, differs in between countries with regard to attitudes towards women, sexuality and reproduction. The ICPD conference held in Egypt presented many challenges

in this regard - challenges that are still to be met and which in turn require culturally appropriate responses.

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Tables

Table 1: Average Number of Children per Woman in Arab Countries

Country	*Average No. of children*	*Country*	*Average No. of children*
Algeria	4.4**	Oman	4.8*
Egypt	4.6**	Palestine	6.48
Iraq	7.0*	Qatar	2.8*
Jordan	3.9*	Saudi Arabia	5.5*
Kuwait	5.0*	Sudan	4.6**
Lebanon	2.8**	United Arab Emirates	4.1*
Mauritania	4.9**	Yemen *	7.5**
Morocco	3.0*		

* Population Report 1998.

** Arab Survey for Children.

Table 2: The time needed to double the population of certain Arab Countries **

Country	*No. of years*	*Country*	*No. of years*
Algeria	28	Oman	14
Bahrain	29	Palestine	16
Egypt	31	Qatar	67
Iraq	19	Saudi Arabia	22
Jordan	21	Sudan	22
Kuwait	21	Syria	19
Lebanon	34	Tunis	36
Libya	21	United Arab Emirates	36
Marocco	30	Yemen	20
Mauritania	24		

** UNDP Population Report

Table 3: The percentage of illiterates in some Arab countries (over 15 years of age)*

Country	*Females*	*Males*	*Country*	*Female*	*Males*
Algeria	51	26	Morocco	69	43
Egypt	61	37	Saudi Arabia	50	28
Iraq	55	29	Sudan	65	42
Jordan	21	7	Syria	44	14
Kuwait	25	18	Tunis	45	21
Lebanon	10	5	United Arab Emirates	21	20
Libya	37	12	Yemen	-	-
Mauritania	74	50			

* UNFPA Population Report 1998

PART II:

THE LIFE CYCLE APPROACH TO POPULATION EDUCATION

Chapter 5

The Adolescent in Today's World: Considerations of Sexual and Reproductive Health

Cristina Fuentes Zurita
Clara Inés Charry Sánchez

Introduction

This study attempts to reflect on the new identities taken by adolescent boys and girls, from a holistic point of view which sees adolescence not just as a stage in life which involves significant biological and psychological changes, but also as a social and cultural construct, in which institutions, standards, values, ideas, status and defining collective and individual practices all interact. We hope to draw attention to the importance of analyzing this subject for the social sciences, giving it a socio-cultural emphasis, since we believe that the condition of today's adolescent boys and girls, and their sexuality, is a social question, not just a biological one. The problems, difficulties or experiences which they have need to be explained through their relationship to other social phenomena, some of which will be discussed below. When analyzing the issue of adolescence from a social perspective, we begin by developing the concept further, together with those of gender and generation as dimensions which reflect some of the organizational structures of the social relations of these age groups and which support the definition and shaping of their subjectivity and identity.

Adolescence, Gender and Generation

These considerations are part of the pilot investigation "Meeting the needs of marginalized adolescents: a new focus on their sexual and reproductive health" which we have carried out on adolescent boys and girls. A workshop activity was conducted, with adolescents of both sexes, students of secondary school age, between 12 and 16, in the suburban district of D.F. (Topilejo) and in San Cristóbal de las Casas, Chiapas. We used the methodological tools of story, drama and group work to explore such topics as: the social imagination of adolescents, self-image, spaces and styles and empowerment (negotiating skills and decision-making).

This investigation hopes to uncover the factors involved in building the social identity of adolescent boys and girls, in order then to generate an education model, which includes consideration for their sexual and reproductive health[1] as a rights issue, rather than a health problem. This point of view goes beyond the idea of sexuality as a problem of birth control, moral control and social control, recognizing rather the need to develop this dimension of the human person as constituent of identity and personal enjoyment, and as a human right. For this reason, we have developed a research strategy which takes us to the centre of the issue, that is, the relationship of adolescent boys and girls with their environment: the impact of communication media, especially television and its role as a source of information, learning and education; the effect of economic and political crisis and restructuring of economic activities; the globalization process and the level of participation or exclusion which is felt in the family and in the system in general and the impact of the market in relation to media in terms of how it models consumption, stereotypes, fashion, taste, values and ideologies.

It is, of course, nothing new for social sciences to talk about adolescent boys and girls, but what is new is the focus which

suggests the need to see them as subjects with rights, actors with their own identity, recognizing that the stage in life we call adolescence is a recent social phenomenon[2] which has become widespread as urban and rural social groupings become incorporated into our modern cultural patterns. Consequently adolescence and youth are not only recognized more and more as stages in life, but also as social conditions, together with the fact that as such they seem to last much longer.[3]

The concept of adolescence effectively began in this century, and is linked to the growth of education, later marriage and family structures in industrial societies. This concept has only recently been introduced in Latin America, together with other cultural changes, which have occurred during the modernization process. The process is associated with the thrust towards industrialization, increasing urbanization, rural migration to the city, growth in formal and open education, and in Mexico, with migration to other cities and to the United States, new consumption and fashion styles and penetration of the mass media among other phenomena.

Adolescence is accompanied by a set of values, which take shape for a particular time and space; it includes a series of practical, overarching behavioural responses, developed over generations, in response to social and material conditions which are expressed through the construction of distinctive lifestyles, in which new meanings are given to old actions and above all, new actions appear with old meanings. In other words, some behavioural patterns are performed for new and different reasons. This means that we can state that youth (including sexuality) has to be analyzed as a life response carried out by adolescent boys and girls. This viewpoint sees the subject as creator and reinterpreter of culture.

We should mention that, under present conditions, much of juvenile behaviour involves resistance, survival and the search for identity or independence as opposed to models of

development.[4] This new situation gives rise to a reading different to that traditionally given to adolescence and located in demography (population growth), biology and psychology (physical and mental health) or in the new focus on epidemiology (aetiology of HIV-AIDS infection) which highlights and defines adolescence as a problem to be controlled or as a state of upheaval.[5] For example: adolescent sexuality has tended to be studied in terms of prevention of early pregnancy or HIV/AIDS or STD and not as an essential element in development of independence.

However, all this requires new concepts, methods and techniques for deciphering contradictory, polarized, and chaotic symbols and universes in modern society, produced by globalization (seen as a new expression of modernity) where individuals paradoxically both model and find their identity. This context requires an examination of the daily life of the young person, and the incorporation of new dimensions in the analysis.[6] This includes the category of gender which is defined as the set of attributes and qualities, cultural and social constructs, which mark social relations and the differences between the feminine and the masculine in a particular context. This category also affords us a partial understanding of what is happening today in the life of young men and women.

Relations between Gender and Generation

The most important changes in the transformation of family life are those involving male-female relations (gender systems), as well as the relationships between generations. These two types of relationship, which are strongly intertwined, give rise to some of the socialization problems experienced by adolescents. We can mention among others the changes in relations with grandparents, specifically with the grandmother and with the parents themselves, especially the mother. These changes generate new conflicts whose effects are most severely felt

during adolescence and which, in turn, will have consequences for the new relationship models developed by adolescent boys and girls. Recent studies show that egalitarian relationships already present in some sectors of society are affecting today's young people, both in rural and in urban areas, allowing both greater solidarity and greater competitiveness. This is especially evident as relations between generations change, with their overlapping consequences of separation, power, etc., and which are highly significant in societies such as in Latin America, where several generations often live under one roof, so that different perceptions and behaviour patterns are interwoven in the life courses of young people in turn generating symbolic transformations.

Violence

According to our observations made in the field study, especially in some of the exercises carried out with adolescent boys and girls, it became evident that there is a high level of verbal, physical, psychological and sexual violence in relations between the sexes. The social violence our society experiences as a generalized phenomenon affects and takes particular expression among adolescent boys and girls. The significance of this discovery is that social violence affects "negotiation" between the sexes, individuals and generations, to the detriment of the relationship, their recognition of themselves including their body, mind and emotions, from the other and from others. The effect of this is to inhibit the social skills required for democracy. It is urgent, therefore, to consider the reasons for violence, in order to identify the strategies which allow its deconstruction at a cultural and educative level, both in the individual and in the group, and the alternative construction of a social design based on respect, tolerance and negotiation.

The Changing Fabric of Society, Migration and Poverty

Another social phenomenon which affected the structure of our study group of adolescent boys and girls was migration. 30% of the sample from Topilejo came from other states and districts adjoining federal district. This aspect needs to be analyzed since it raises questions relating to the relationship between migration, identity and the integration of the adolescent subject with his or her peer group. Migrant families often experience the loss of social support networks or find difficulties in confronting, or resolving conflicts among themselves. What needs to be understood is the extent to which ignorance of the local picture (customs, myths, legends, etc.) enables construction of a new identity, which competes and generates changes and divisions. How the migratory phenomenon relates to aspects of the mental health of the adolescent and their families and the well-being of the subjects in terms of building citizenship and democracy are also key issues to be considered. Consideration of these aspects of migration and its effect on the adolescents in our country is urgent and will be considered in a later stage of the research.

Institutions

Another important point considered in this study is the role of institutions (the family, the school and the state) as regulators and integrators of social life. Institutions do not fulfill the needs of adolescent boys and girls. As has already been stated, families are also changing internally. Faced with society and the market, they themselves look for ways of coping together with the need to respond to their children's requirements, using the cultural, economic, ethical and educative resources available. This also gives rise, in the context of the crisis, to restructuring of the economic system.

The State has been weakened throughout the world as an integrator, as a social regulator, as an administrator of justice and as a political authority to represent society and the interests

of the nation. Mexico is no exception. At the same time, the school and the education system, in general, have been undergoing their own crises, especially in basic education. Education has become more a factor in social differentiation, rather than one of social development.

In turn, the media is responding largely to market interests with not even a slight sign of change in its operational strategies. Its transforming wealth is not directed at resolving or attending to minority problems. On the contrary, the growth in the volume of the messages leads to uniformity, cultural impoverishment, simplification and repetitive exaggeration of fiction, values, sentiments, attitudes, fashion and manners.

Family

At the same time, the traditional hierarchical family model still exists in many parts of Mexico, in which rules and standards are not agreed, but in which roles and functions are assigned according to the position in the family (father, mother, older or younger siblings, etc.). This situation has been undergoing significant changes. The traditional family acts above all as a moral guide for those in subordinate positions within it, and not as a means to empower the subjects. In the present scenario, the need for families to have not only this role, but also to adapt to and educate their subjects and empower them (including fathers, mothers, uncles and aunts, etc.) was particularly important. Adolescents expressed problems with their step-parents, and with their mothers' frequent changes of partner; with interfering relatives; with mothers who go out to work and hit them for not looking after younger siblings, and with grandparents who do not share their anxieties and interests.

Communications and Stereotypes

The media play an ever-increasing role in society, in particular television, and through it, the subjects can enter a different,

varied world of images, entertainment and information. In this way television has become the bridge linking the individual, family and private space to the social, collective and public space. It brings immediate reality closer to global reality, linking the individual to the rest of humanity without mediation. This allows us to state that the method of defining individuals by means of their socialization space and social relations has become weakened and these referents now have diffuse, wider, uncertain and multiple connotations, leading to growing disassociation between the objective world and the concrete subjective space.

This disassociation becomes a problem of analysis for social sciences and of particular interest for our study on the new identities of adolescent boys and girls. When investigating the image and concept which adolescent boys and girls have of love, gender, body image of men and women, eroticism, engagement and negotiation in decision-making, among other things, we find a clear tendency to react according to rigid and preconceived parameters which respond to models offered by society itself, but also, and to a large extent from television especially from soap operas, which are taken from society and are responsible for diffusing and reinforcing such models.

For example, as regards the image and representation of love, engagement and falling in love, responses (verbal, graphic, imagined or fictional) do not go beyond the repetition of romantic ideas and images, typical of the soap opera. As regards the gender system, it is built on competitive relationships, separations, verbal violence, blackmail and polarization, so that male and female adolescents are trapped, to the point of being prevented from forming equitable, harmonious and friendly relationships. If we set this into the context of the stage in life through which they are passing, it becomes very significant.

The body image of beauty for male and female adolescents complies with the traditional patterns based on physical

appearance. For men, curves and the size of the breasts, for women, strength and daring. In this regard, a need is perceived for boys to express these features of their masculinity and in girls their preoccupation with being accepted as they are as well as boys' requests for their feelings "also" to be considered. Similarly, eroticism is centred exclusively on genitalia, with no recognition of the relevance of other sources. It is notable that negotiation in decision-making appears to be absent, decisions often being taken for reasons other than the interests of the individual or their partner. Lack of information and cultural resources, verbal violence and blackmail are all factors involved. This applies to falling in love, making a commitment, ending a relationship or the commencement of sexual activity.

Traditional stereotypes are taken on by the sexes. It is also noted, however, that these patterns are not made to measure and do not contain elements for deconstruction or reconstruction within their own subjective space. There is an imbalance between the images taken from the world and the social, collective and public environment, and the concrete, personal, subjective and private reality. Although this situation does not in any way respond only to the impact of media and television, it is a clear source of images and models, which serve to supply stereotypical behavioural responses, as well as the representational systems of symbol and myth.

This brings us to the need to plan the development of educational models in which the adolescent subject can rebuild the framework values which organize his or her interactions, while communication media have a strong impact on mass culture and adolescent culture by displaying ethical referents for discernment.

Conclusion

As social scientists our challenge is to develop a line of thought which gives recognition to the everyday life of men and women,

and which involves a critique of traditional social research. At the same time, educational models which encourage an awareness of the ways adolescents act and feel, including the deconstruction of violence, gender, body image, prejudices and taboos on sexuality, etc., in various public contexts, namely school, family, institutional (health, etc.) environments, and in the intimate context need to be developed. These models should be based on research, which considers adolescents as empowered subjects, rather than deviants or social categories with health problems.

Hence the importance that in the search for the common good, the development of the public virtues of social co-operation, such as civility, tolerance, rationality, the sense of equity, respect, self-esteem, be included.

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[1] Reproductive health is a general state of physical, mental and social well-being, not simply the absence of illness or disease, related in all its aspects to the functions and processes of the reproductive system. Reproductive health therefore alludes to the capacity to enjoy a satisfactory sex life, without the risk of conception, and emphasizes the freedom to decide when and how often a woman will bear children. See: Fuentes, Cristina. 1999. "Algunas dilemas éticos en los procesos de investigación sobre reproducción con adolescentes y jóvenes". In: *Perinatología y Reproducción humana.* Vol. XIII, No. 1, Jan-Mar, p.27.

[2] See: Fuentes, Cristina. 1996. "Modos de vida en los tiempos de hoy: Reflexiones para el estudio de las identidades juveniles". In: *Revista EBA áurea.* Mexico: Universidad de Querétaro.

[3] See the conclusions of the article of Crisitina Fuentes. 1999. "Algunos dilemas éticos en los procesos de investigación sobre reproducción con adolescentes y jóvenes". In: *Perinatología y reproducción.*

[4] For example, adolescent pregnancy as a form of resistance and search for status and recognition.

[5] See: Rodriguez-Tomé and Bariaud. 1997. *Regardes actuelles sur l'adolescence.* France: Paidos.

[6] For example, leisure, lifestyle, cultural and aesthetic output such as language, fashion and those forms of socialization which they generate with their various associations.

Chapter 6

Information Provided by Rural Mothers to their Daughters Concerning Reproductive Health

Chanya Sethaput
Pimonpan Isarabhakd

Introduction

It is generally accepted that the earliest social influences on an individual are those of the family. The mother and the father are the first adults to whom a child relates and it is they who therefore provide the role models for subsequent sexual development. In Thai families, a father controls family decisions concerning extra-household matters. A mother, on the other hand, takes charge of the house and compound. Her responsibilities include important household decisions, doing all the household chores, looking after everyone in the house, childcare and child rearing (Yoddumnern-Attig et al, 1992). This implies that it is the mother's role to socialize children's behaviour and to develop their personal qualities.

However, with regard to sexuality, research has found that in Thai families information on sexual or reproductive health issues is rarely imparted to children. In fact, the transmission of sexual knowledge to children by parents, whether directly or indirectly, is so low that children usually seek such information from the world outside their family (Porapakkham et al., 1986). Results from many surveys indicate that although adolescents want sex education, they are less likely to receive sexual information from members of their family than from their friends and the mass media or, in the case of those still studying

or who have not finished secondary school, from teachers (Suwanitchart and Kunanithipong, 1987; Pichaisanith et al, 1986; Isarabhakdi, 1995).

There are several reasons why adolescents do not receive sex education from their parents. Firstly, parents or adults may have no knowledge about sexual matters so they cannot talk to their children about them. Secondly, parents with traditional values about sex may feel ashamed to talk openly with their children. Thirdly, as parents do not agree with premarital sex they are not willing to provide their children with sexual knowledge, believing that they will learn about it when they grow up (Newcomer and Udry 1984 citing Furstenberg et al; Reiss, 1981; Roberts, 1978 and Norman and Harris, 1981). Nevertheless, some anthropological research in Thailand reveals that there are mothers and/or grandmothers who have on occasions told their daughters or granddaughters about sex directly (Yoddumnern-Attig et al, 1992).

From the foregoing, it is evident that children and adolescents in Thailand have little opportunity to obtain sexual knowledge unless they attend secondary schools, where sex education, or family life education as it is called, is integrated into some areas of the curriculum. However, less than half of the children finishing the compulsory part of their education at primary school subsequently enroll in secondary schools, particularly in rural areas. Many of these then leave their villages and families to find jobs in Bangkok and other big towns. For this reason, rural adolescents are the most disadvantaged when it comes to learning about sex, having received no form of instruction from their school or their family.

Teenagers with no basic knowledge about sex are easily drawn into a fascinating and dangerous society. For example, in Bangkok, rural girls who have migrated from their homes often find themselves in sexually vulnerable situations, some even drift into prostitution. If, however, they have learnt about

sexuality from their parents or other older relatives before leaving home, they may have a better understanding of the dangers they face and be able to avoid such risks.

Currently, there is a lot of discussion going on as to how parents may be persuaded to pass on sexual knowledge to their children for it is recognized that if parents were to do this, it would provide their children with a positive and informed attitude about sex and thus serve to protect them from the growing social pressures that expose them to the rapidly spreading sexual diseases. For sex education, by covering the areas of biology, hygiene, psychology and the social environment, involves not only learning about the sexual and reproductive system but also about good attitudes and proper behaviour.

A Study of Mothers and Daughters in Rural Areas

In order to assess the existing attitudes to sex education in rural areas of Thailand and to find out whether mothers pass on information about sexual issues or reproductive health to their daughters and how effective this is, a study was carried out in October 1991 as part of a research project entitled, "The Relationship between Familial and Non-familial Influences on Sexual Values of Female Adolescents in Amphoe Nang Rong, Changwat Burirum". This study examined three questions:

- Do rural mothers tell their daughters about sex, and if so, what do they talk about?
- Does sex information given by rural mothers affect the sexual knowledge of their daughters?
- Do rural mothers with varied degrees of sexual knowledge pass on sexual information to their daughters differently?

Source of Data

Data for the study was collected in October 1991. From the household listings of 52 villages in the Nang Rong district, only those having mothers with daughters aged between 15 and 19 were selected. Using two separate interview schedules, one for mothers and another for the adolescent daughters, 472 mothers and daughters were interviewed. During the interview, mothers and daughters were kept sufficiently far apart to avoid them overhearing each others responses since some sets of questions were identical.

In this study, data on the age of the mothers, level of mothers' sexual knowledge, level of daughter's sexual knowledge, amount of sexual information given to the daughter, level of sexual information that the daughter received, and the reason for telling or not telling daughters about sex were analyzed. The survey data was supplemented by information gathered at focus group discussions with rural adults who have adolescent children. The focus group discussions were conducted in the North and the Northeast of the country.

Results

It should be noted that socio-economic factors were not taken into account because the characteristics of the target population were considered to be similar. Most mothers earn their living by growing rice and cassava. They have a low level of formal education (84.5% finished Primary 4 or compulsory education at the time). The average number of years of school attendance for rural mothers is 3.6 while their daughters spend 6 years on average in school (92.4% finished Primary 6). In this study, the average age of the mothers was 46 and 17 for the daughters.

On testing the sexual knowledge of both mothers and their daughters, using the same set of questions, the mothers were found to have a lower average score than their daughters. Out of a maximum of 16, the mothers scored an average of 7.3 while

their daughters averaged 8.3. However, the test may be considered rather difficult for rural people, given that they have only primary education, and even more so for the mothers, who have never received any sex education in school. The daughters, on the other hand, having recently finished their primary education (at about 13 years of age) would probably have gained some knowledge at school.

The mothers and daughters were then asked about the sort of sexual information, if any, that had been passed on, either directly or indirectly. The ten specific issues surveyed, covering 30 minor topics in all, were as follows:

- Dating - having a boyfriend; talking with men; and going out alone with men.
- Premarital sex - touching boys; meeting boys in secret; and remaining a virgin until marriage.
- Partner selection - appropriate age of courtship; characteristics of spouse; and the wealth of spouse.
- Family life - how to please your husband; how to take care of the house; and how to prepare to have children.
- Menstruation - what is menstruation; prohibitions during menstruation; and personal hygiene during menstruation.
- Reproduction - how a child is born; reproductive organs of men and women; and the appropriate age for having a child.
- Pregnancy - when can a woman conceive; in what part of the body does the foetus develop; symptoms of pregnancy.
- Contraception how to prevent pregnancy; forms of contraception; and what the most effective methods of contraception are.
- Sexually transmitted diseases - what they are; how can they be prevented; and whether they can they be cured.
- AIDS - what is AIDS; how to prevent AIDS; and who is most at risk from AIDS.

The topics that the mothers had at some time referred to or talked about are listed in order of frequency in Table 1. From

this it can be seen that the topics rural mothers discuss most frequently with their daughters concern premarital sexual relations and dating. The mothers usually warn their daughters to be careful when coming into contact with men and to avoid being alone with them. The next most frequently mentioned issues are those concerning menstruation and becoming a future wife. The biological and health topics, such as reproduction, pregnancy, contraception and including sexually-transmitted diseases, are the ones referred to the least. This may be because the biological aspects of sexuality are technically difficult for these rural mothers to explain or because they have insufficient knowledge themselves. Some mothers may mention the AIDS disease but not other sexually-transmitted diseases (STDs) which implies that rural mothers have little knowledge about STDs in general but may have learned about AIDS from the nationwide awareness campaign.

Although there is evidence that rural mothers have sufficient knowledge of sexual issues such as birth control, it was important to find out why they do not often talk to their daughters about them. The mothers gave a range of reasons, which are listed in Table 2. The results showed that some mothers think that their daughters are still too young so it is not a good time to tell them, believing it would be better to wait until their daughters are going to be married or even until after they are married. Other mothers do not tell their daughters either because they want them to find out by themselves or because they do not know what to tell them. This appeared to verify the findings from the sexual knowledge test, that some rural mothers have inadequate sexual knowledge. In fact, some of the mothers in the focus group discussions thought that teenagers nowadays know more than they did when they were that age. One mother said that, "When I was my children's age, I did not have any idea about sex, I thought my parents just slept together and did nothing".

In this study, the relationship between mother and daughter was also examined by analyzing the age of the mother, her sexual knowledge and that of her daughter as well as the level of sexual information transmitted.

In Table 3, the mother's ages are recorded in two groups: young (33-45 years old) and old (46-68 years old). The mean age of the mothers interviewed was 45 years. Similarly, the level of sexual knowledge of the mothers is divided into two categories: low level (0-7 scores) and high level (8-16 scores). As stated above, the mean score was 7.3. Using cross tabulation, it is evident that the younger mothers have more sexual knowledge. Using the chi-square test it is found that the relationship between the age of the mothers and the level of sexual knowledge is statistically significant at .01 level. That is, the ageing of the mothers affects their sexual knowledge. This may be because the older generation had less opportunity to receive sex education.

Another question the study intended to examine is whether it is older or younger mothers who give more sexual information to their daughters. Therefore, information given by the rural mothers to their daughters was classified in two levels according to the number of sex education topics referred to: low, where the level of sexual information was between 0-14, and high where it was between 15-30. The mean level was 14.38. The results in Table 4 show that the age of the mothers has no affect on the amount of sexually-related information passed to their daughters.

Before attempting to establish the relationship between the sexual knowledge of the mothers and the sexual information given to daughters, the assumption was made that the more knowledge about sex the mothers have, the more information they will pass on to their daughters. However, although this hypothesis was shown to be correct among this sample of rural mothers, the difference in percentages was not found to be statistically significant (see Table 5).

Findings presented in Table 6 also show that there is no relationship between sexual information given by rural mothers and the sexual knowledge of their daughters. It was expected that if mothers had relayed more information on the subject, their daughters would have a higher level of sexual knowledge. It is evident, however, that the mothers of those daughters with a high level of sexual information were fairly equally endowed with low or high levels of knowledge themselves. This may confirm the view that adolescents gain sexual information from sources other than their family and that girls receive more information concerning sex and reproductive health from their friends and mass media than their mothers (Sethaput, 1993; Isarabhakdi, 1995).

Discussions

The findings of this study indicate that rural mothers do pass on sexual knowledge to their daughters but that some aspects are more likely to be raised than others. Thus, it appears that mothers talk most commonly about those issues which reinforce the traditional values of Thai people, particularly the ones related to virginity, such as dating and premarital sex. However, these topics are raised not in connection with safe sex but rather as a warning to the girls about coming into contact with males or about avoiding situations where they may find themselves alone with men. These issues reflect the socialization process in rural families.

In Thailand, girls are trained to be sexually reserved, that is, they are not allowed to have a close relationship with boys. Being friendly, touching or having an intimate relationship with any man before marriage will be a cause for gossip, and a young woman who does this may be frowned upon and condemned as a loose girl by neighbours and relatives. Most Thais view premarital sexual relations "as the man's gain and the woman's loss". Furthermore, if a girl's behaviour is regarded as "loose", it

affects the moral standing of her parents within the community (Pramualratana, 1992). Therefore, young Thai females are given stricter training on how to behave, more family and household responsibilities and much less social freedom than young males (Archananichkul and Havanon, 1993).

The study also indicates that the mothers do not consider their daughters old enough to be given information on sexual matters until they are about to marry or involved in courtship. This also reflects the cultural attitudes of rural Thailand. In these areas girls begin menstruating at the age of 14 to 15 years and it is this that marks their entrance into womanhood and signals marriageability. Although among their own social group this is considered to be too young an age for marriage, the girls are encouraged to begin acting like women. For this reason they may no longer associate with male friends. However, because single women are expected to be sexually innocent, they may be informed about reproduction and associated behaviour only when the need arises (Yoddumnern-Attig et al., 1992). Traditional Thai society views the onset of sexual relations as a passage to marriage and the starting of a family. In other words, marriage is seen as an institution which legitimizes culturally appropriate sexual relations between a man and a woman (Vaddhanaphuti, 1993; Whittaker, 1995).

Discussions with groups of parents of rural youth show that parents are concerned about the sexual behaviour of daughters. However, although the parents felt that teenagers nowadays had more opportunity to interact with the opposite sex none of them talked directly to their children about sexual conduct. Some felt uncomfortable about raising the subject, especially with teenage girls, while others did not want to distract them from their school work or intervene in their children's daily life. Their children's schooling appeared to be the parents' overriding concern and they wanted them to get as much education as they could. All parents expected their children to be "better" than

themselves and wished their children to finish school, get a good job and be independent. These concerns about their children's education apparently deterred some parents from talking to children about sex, as one explained, "we do not want to interfere with their life, we want them to concentrate only on studying. If we were hard on them, it would encourage them to do things that we didn't like".

Nevertheless, parents might indirectly advise their children by talking about what kinds of friends their children should socialize with or go out with, particularly in view of the fact that the study revealed dating to be one of the most frequently raised topics, and one related to having a boyfriend. On the basis of this study, however, there is no evidence for assuming that the mothers do not consider sexual issues sufficiently important enough to discuss with their daughters. Neither can we ascertain that mothers actually have less knowledge of sex and reproductive health than their (better educated) daughters. Even those mothers who may have gained knowledge through experience are no more likely to pass on such information to their daughters. Thus, it may be concluded that it is the traditional norms pertaining to sexuality that discourage them from talking about these topics.

Conclusion

The findings highlight the fact that at present mothers are not a major source of knowledge about reproductive health. Moreover, young rural women rarely have the opportunity to learn about sexuality or reproductive health issues in school because most rural adolescents have only 6 years of compulsory education at primary level while family life education or population studies are only taught at secondary level. Consequently, family life education programmes in the formal educational system do not have a large effect on adolescent sexual behaviour. It is our belief therefore that adult education

should place more emphasis on reproductive health education and we recommend that such knowledge be transmitted through both non-formal and informal education programmes using non-formal schools, parents and the mass media.

At present, after finishing compulsory education, many adolescents continue their study in non-formal schools. Sex education should be introduced to these young people through non-formal educational institutions.

Parent and child communication is found to have an effect on the premarital attitudes of young females (Isarabhakdi, 1997), therefore mothers should be encouraged to overcome cultural norms regarding sexuality and provide useful reproductive health information to their children. Programmes aimed at providing rural adolescents with accurate sexual and reproductive health information through the mass media, and involving their families as an informal method of education, should be designed.

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Tables

Table 1: Sexual topics that rural mothers talk to their daughters about

Topics	*% of times discussed*
Premarital sexual relations	89.6
Dating	85.6
Partner selection	70.6
Menstruation	68.6
Family life	60.2
Pregnancy	33.3
Reproduction	28.4
AIDS	26.9
Contraception	24.4
Sexually transmitted diseases	21.2

Table 2: Reasons given by rural mothers for not informing their daughters about sex

Reasons	*%*
Will tell them when they get married	42.3
Prefer to let them find out by themselves	25.3
Never think to tell	10.1
Will tell them when they have boyfriends	9.6
Don't know what to tell	8.5
Will tell them when they are grown up	2.5
Will tell them if they ask	1.7
Total	**100.0**

Table 3: Percentage of level of sexual knowledge of rural mothers by age group

Level of sexual knowledge	*Age of mother*			
	Young		*Old*	
	%	*(n)*	*%*	*(n)*
Low Level	40.0	(96)	59.6	(142)
High Level	59.0	(138)	40.3	(96)
Total	**100.0**	**(234)**	**100.0**	**(238)**

Table 4: Percentage of level of sexual information given by rural mothers to their daughters by age group

Level of sexual information	*Age of mother*			
	Young		*Old*	
	%	*(n)*	*%*	*(n)*
Low Level	51.3	(120)	50.0	(119)
High Level	48.7	(114)	50.0	(119)
Total	**100.0**	**(234)**	**100.0**	**(238)**

Table 5: Percentage of level of sexual information given by rural mothers to their daughters by level of sexual knowledge of mother

Level of sex information given to daughters	*Sexual knowledge of mother*			
	Young		*Old*	
	%	*(n)*	*%*	*(n)*
Low Level	54.2	(129)	47.0	(110)
High Level	45.8	(109)	53.0	(124)
Total	**100.0**	**(234)**	**100.0**	**(238)**

Table 6: Percentage of level of sexual knowledge of rural adolescents by sexual information given by their mothers

Level of sexual knowledge of adolescent	*Sexual knowledge of mother*			
	Low		*High*	
	%	*(n)*	*%*	*(n)*
Low Level	42.7	(102)	43.3	(101)
High Level	57.3	(137)	56.7	(132)
Total	**100.0**	**(234)**	**100.0**	**(238)**

Chapter 7

Ageing in Cuba

Raúl Hernández Castellón

Introduction

Various factors have contributed to the development of Cuba's population this century and these differentiate Cuba from many Third World countries. Like other Latin American countries, Cuba received a considerable number of immigrants between 1900 and the 1930s, mainly from Spain and the Antilles. 75% of these immigrants were men, the majority of whom were single. This had the effect of altering the age and gender characteristics of the population which, in turn, influenced the reproductive rate as these people tended to be better educated and have a lower measure of fertility than the national population.

This high wave of immigration was a response to the demand for workers in the sugar cane factories in which American capital was being invested. At the same time, this investment led to great efforts being made to reduce the mortality rate in Cuba, to increase the educational level of its population and to extend the already incipient urbanization process. These and other factors contributed to the early Cuban demographic transition that resulted in the country being one of the few in the region to have a slow rate of population growth in the 1950s.

There was also a significant reduction in the mortality rate after 1959 when a major investment was made in public health, with a large number of health specialists and technicians being trained and a free and universal health system being established for everyone on the island. In addition, the increase in the

educational level of the population, the notable inclusion of women in the workforce, the availability of contraceptives and the fact that abortions were allowed, led to a large decrease in the fertility rate. This reduction in the fertility rate lasted for several decades and led to a corresponding acceleration in the Cuban population's ageing process.

Factors affecting the current demography of the country include early marriage, a high fertility rate among those under 20 years of age as well as a high number of abortions among this population group. It is also important to note that abortion, one of the two main regulators of fertility, has had a detrimental effect on women's health. Although the abortion rate has been declining steadily in recent years, it has also been pointed out that well over half the women who rely on the rhythm method of contraception based on the menstrual cycle become pregnant and that this could change the apparent downward trend.

In this analysis we intend to examine some of the demographic aspects associated with the accelerated ageing process that Cuba has witnessed in the last decades, beginning with a review of the demographic transition which influenced this process.

The Cuban Demographic Transition

The first stage of the demographic transition occurred between 1904 and 1934. By 1928, the Americans had already invested some 1 500 million dollars in Cuba and thus generated a great wave of immigration to meet the workforce requirements. These immigrants included some 750 000 Spanish and about 250 000 Haitian, Jamaicans and Puerto Ricans. As has already been stated, the fact that these immigrants were largely single men of working age affected the age and gender balance of the Cuban population. Parallel to this, the high degree of urbanization and

the relative advances in education also influenced the fertility rate. However, the particular characteristic of this first stage was the fact that it did not produce a population explosion such as those which occurred in the developing countries after the 1950s (Hernández, R. 1988).

In this first stage, life expectancy started to rise, from 33.2 years in 1899 to 41.5 years in the 1930s. Fertility, too, began to decrease though somewhat later, going from a reproduction rate in the 1920s of 2.8 daughters per woman to 2.2 in 1931. Natural growth was therefore moderated, fluctuating between 13 and 19 persons per one thousand inhabitants (Hernández, R. 1988). An important aspect of the second stage of the Cuban demographic transition was the reverse in the pattern of migration. In this period, Cuba became a country of emigration on account of economic and political factors, the most significant of which was the revolution of 1959 which resulted in a series of changes to the political, economic and social structure. The migration pattern turned round again during the last period of the demographic transition. Between the 1960s and 1974 the external migrant balance went from zero to 584 000 persons. At the same time, the birth rate fell from 35 births per one thousand inhabitants between the 1930s and 1934 to 28 per thousand from 1959 to the 1960s. The fact that it rose again to 35.3 per thousand during the period 1960 to1965 was the result of various factors (ibid.).

Another characteristic of the Cuban demographic transition is the fact that this population development took place in the midst of the process of social development which diminished the differences between the population in terms of various socio-demographic factors, such as land distribution, education, employment, etc. (ibid.).

In the last two decades, there has been a quite remarkable change in the mortality rate as can be seen in Table 1.

Fertility

Changes in the fertility rate are also reflected in the pattern of demographic transition. Until 1953, there was a gradual rise in the fertility rate before it reverted to earlier levels. However, different age groups weighted the overall rate in different ways: the fertility rate for women of 35 years and over went down from 35% in 1953 to 22% in 1975, while that of women under 20 rose from 8.2% in 1953 to 23.5% in 1975. During the second phase of demographic transition, when the homogenization process produced not only demographic but also social changes, the differences in the fertility and mortality rates were also reduced considerably according to social groups, the urban and rural zones and the political administrative divisions.

The last three decades have witnessed acceleration in the transition, too, with the increased educational level of women, their participation in the labour force and the greater availability of family planning methods, among other things, leading to a drastic reduction in the birth rate.

One of the most significant reductions in fertility to occur in the world has taken place in Cuba. In particular, the period 1971 to 1981 saw a great slowing down in the birth rate from 20.8 per thousand inhabitants to 14 births per thousand at its close. In Figure 1 crude birth rate is shown. Between the 1970s and 1990 the gross reproduction rate went from 1.80 daughters per woman to 0.89, that is to say, below the replacement level (ibid.).

Population Age Structure

The two largest age-groupings that will be most affected by the current changes until the year 2025 are the under-15 and the

over-60 years old, although each will be affected in different ways. The size of the former will steadily reduce while that of the latter will not only increase but will eventually outnumber the other as a result of the great reduction in the fertility rate. Figure 2 illustrates the recent evolution of both groups.

It is possible that the rate of reduction in the under-15 age group may have become less marked in recent years because of a scarcity of such contraceptives as the condom, contraceptive pills and similar products as a result of the trade embargo being enforced by the United States. This may also explain the moderate increase in fertility recorded in 1997.

Population Ageing

During the first decades of this century, the Cuban population aged 60 years and above was of a moderate size. In 1899, there were only 72 000 people in this age group but by the 1950s it numbered 427 000. In 1990, the number of elderly people had reached more than 1.2 million, some of them descendants of those who came to the country six decades before. It is commonly estimated that this number will have doubled by the year 2020 to some 2.5 million. This estimate is based on the fact that the survivors of the baby boom between 1960 and 1965 will have reached the "third age". In percentage terms, this age group, representing 13% of the total population in 1996, will have already reached 13.5% in the year 2000 and is expected to reach 25% by 2025 (Hernández, R. 1997). The classic age structure of the pyramid has now shifted and by the year 2025 it is expected that the ageing population structure of Cuba will closely resemble that of the industrialized world.

Another mirror of population ageing is the analysis of dependency ratios. This serves a dual purpose in that it not only

reflects the changes in the structure of the population but also indicates the size of the "burden" that has to be carried by the active or employed age groups, either in relationship to the young or the old, or to the population as a whole. An example of the size of the challenge that will have to be faced in the future as a result of the ageing population is given in Table 2. This shows that the ratio of the older population is expected to double between the years 1995 and 2025 while the ratio of the young will decrease, although to a lèsser degree, because the decrease in fertility will not be so spectacular as that which occurred in previous decades.

Another of the important issues concerning population ageing is related to the active population age-structure evolution, beginning from the age of 17 years. This process is illustrated in Table 3. The table shows how the balance between the various age groups of the active population will tip as the weight moves from the younger to the older groups. In particular, the 25- to 34-year-olds will lose ten percentage points between 1995 and 2015 while, in contrast, the age groups 35-44 and 45-60 will both gain significantly.

The economic crisis that affects Cuba also poses a great challenge, as the social security budget is very large. Expenditure on social security increased by 2.4% between 1980 and 1993 and that by 2010 this expenditure will have to be in the order of 3 500 million pesos providing that there are no changes in social security legislation and that all people exercise their right to retire on reaching the required age. The foregoing combined with the anticipated growth in the population of the third age and the increased longevity of those retired on pensions indicate that there will have to be an examination of the situation from this perspective particularly in respect to the financing of social security and the age of retirement.

Although by the year 2000 the number of people aged 60 years and over will have increased, the far greater increase in the year 2025 will present a considerable challenge, particularly as there will be an ever-growing number of very elderly citizens to care for. This situation is illustrated in Table 4.

Conclusion

Cuba has witnessed dramatic changes in fertility levels coupled with an increase in the percentage of ageing population reflecting similarities more with industrialized economies than with the developing world. These will present fresh challenges to the government and to society in general with which Cuba is already beginning to deal.

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Tables

Table 1. Cuba: Selected mortality measures

YEARS	*Mortality rate (1)*	*Infant mortality rate (2)*	*Maternal mortality rate (3)*
1970	27.7	38.7	70.4
1975	20.8	27.5	68.4
1980	14.1	19.6	52.6
1985	18.1	16.5	30.8
1990	17.6	10.7	31.6
1995	13.4	9.4	32.6
1997	13.8	7.2	21.6

1. Live births per 1 000 inhabitants.
2. Deaths of children below one year old per 1 000 live births.
3. Maternal mortality per 100 000 live births

Source: Ministerio de Salud Pública. 1998. *Anuario Estadístico 1997*, pp. 14 and 23. La Habana. / 1998. *Salud en el tiempo, p. 1*. La Habana.

Table 2. Dependency ratios of the Cuban population

Years	*Social(3)*	*Young(1)*	*Old age(2)*
1995	53.4	34.1	19.3
2000	53.2	32.5	20.7
2005	52.4	29.4	23.0
2010	53.0	27.1	25.9
2015	54.8	26.3	28.5
2020	59.2	25.8	33.4
2025	69.5	27.1	42.4

1. The ratio of the population aged under 15 to that aged 15-59.
2. The ratio of the population over 60 to that aged 15-59.
3. Sum of young and old age dependency ratios.

Source: Calculations based on ***Escenarios***. 1996.

Table 3: Cuba: Evolution of the age structure in the years 1995-2015 (population in thousands)

Age-groups	*1995*	*2000*	*2010*	*2015*
17-24	1617	1330	1398	1474
25-34	2352	2197	1803	1625
35-44	1660	1974	2256	2134
45-60	2172	2316	2452	2784
Total	**7801**	**7817**	**7909**	**8017**
Percentage distribution				
17-24	20.7	17.0	17.7	18.4
25-34	30.2	28.1	22.8	20.3
35-44	21.3	25.3	28.5	26.6
45-60	27.8	29.6	31.0	34.7
Total	**100.0**	**100.0**	**100.0**	**100.0**

Source: ***Escenarios***, p. 88. 1996.

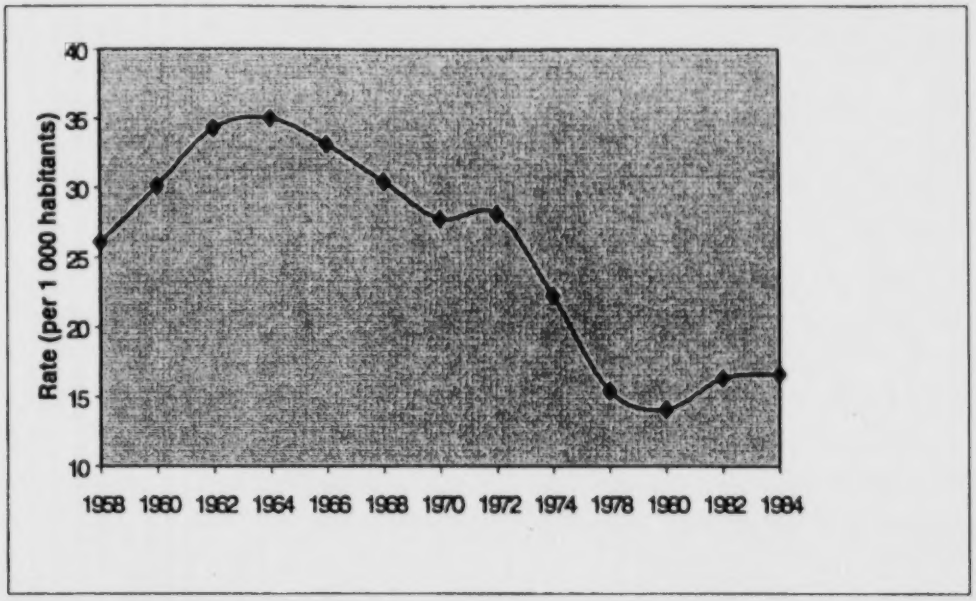
Table 4. Cuba: Selected statistics of the population aged 60 years and older

YEARS	*1950*	*1995*	*2025*
Total population (thousands)	427.0	1384.1	2948.8
Percentages of older people	7.3	12.6	25.0
Age ranges (exact figures)			
60 - 64	143.0	394.5	964.2
65 - 69	114.0	305.9	589.8
70 - 74	84.0	279.6	536.7
75 - 79	53.0	207.6	421.7
80 +	33.0	196.5	436.4
Age ranges (%)	***100.0***	***100.0***	***100.0***
60 - 64	33.5	28.5	32.7
65 - 69	26.7	22.1	20.0
70 - 74	19.7	20.2	18.2
75 - 79	12.4.	15.0	14.3
80 +	7.7	14.2	14.8

Source: Hernández, Raúl. 1997. ***Escenarios 1996***, p. 14.

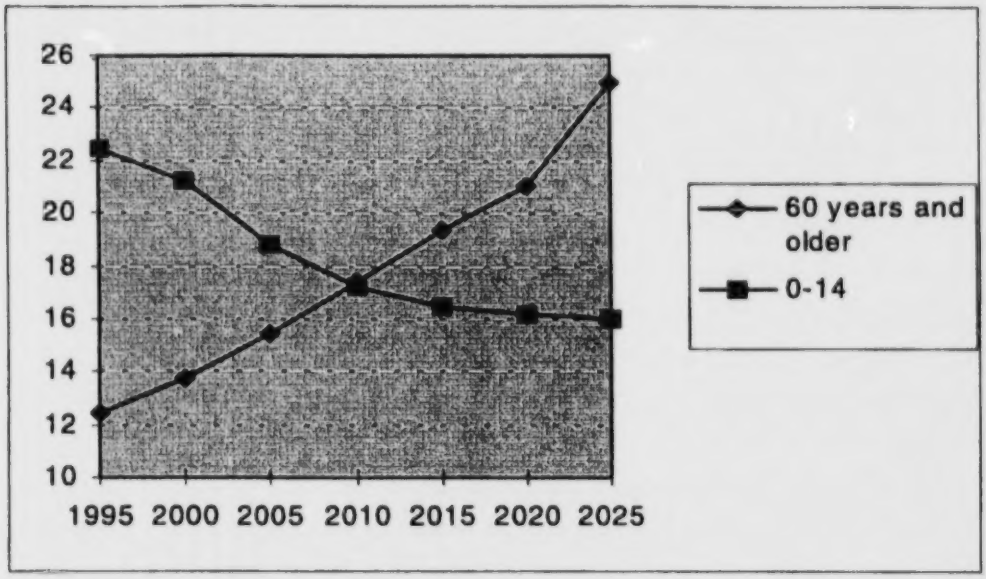
Figures

Figure 1: Evolution of birth rates 1958-1997



Source: CEE. 1992. MINSAP.

Figure 2: Evolution of age structure by percentage of the Cuban population according to the under-15 and the over-60 age groups



Source: ONE. 1997.

PART III:

POLICY MAKING FOR POPULATION EDUCATION

Chapter 8

The Effect of Education on Fertility in China

Xu Mingdong

Introduction

Since the early 1970s, China has experienced a dramatic fall in the total fertility rate (TFR) from an average of 5.81 children per woman in 1970 to only 1.84 children in 1994, which is lower than the replacement level (see Figure 1). This rapid decline in the TFR is attributed to two major factors: rapid socio-economic development and the successful implementation of the national family planning programme which was launched in the early 1970s. However, as well as economic and health policy changes, there have been accompanying social changes in both urban and rural sectors of the society and here we intend to examine the effect of education, especially that of women, on fertility in China.

Under Chinese law, women enjoy equal rights with men in all matters, including education. Persistent efforts have been made by the Chinese Government to popularize education and improve people's educational attainments. Due to these efforts, the illiteracy rate for young people of both sexes has declined and their educational attainment increased. Since the foundation of the People's Republic of China, 110 million formerly illiterate women have become literate, bringing down the proportion of women in the total illiterate population from 90% in 1949 to 32% in 1992. The national enrolment rate of female children at school age increased

from 15% in 1949 to 96.3% in 1995. By the end of 1997, the number of female graduates and post-graduates was 1.24 million, amounting to 36.42% and 30.35% of the total respectively.

Nevertheless, the educational level of Chinese women is still lower than that of men. Data from the 1990 census show that the ratios of male students to female students in universities, senior middle schools, junior middle schools and primary schools were 1:0.39, 1:0.64, 1:0.64 and 1:0.92, respectively. Chinese women, particularly in rural areas, have far less access to higher education than men, and their rate of illiteracy remains relatively high. Statistical data indicate that in 1990 the illiteracy rate for females aged 15 years and older was 32%, whereas that for males in the same age group was only 13%.

The Relationship Between Education and Fertility in China

In order to examine the relationship between education and fertility over a period of time, a graph showing the data on the primary school educational attainment of both sexes and the TFR over time has been plotted (see Figure 2). The data on primary school educational attainment in China was obtained from the specific data for each age group contained in the 1990 census reports although this first needed to be converted by transforming the age at the time of the census into the year of birth and, from this, calculating the year of graduation from primary school according to the educational system of China.

By comparing Figure 1 and Figure 2 it can be seen that China experienced both a remarkable increase in educational attainment and a remarkable decline in the TFR during the last half of the 20th century. However, it is also evident that educational attainment levels started to rise earlier than the TFR started to decline.

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Furthermore, the educational attainment of males is shown to be higher than for females although the gap between the sexes has been narrowing.

The current relationship between educational attainment and the fertility rate of women of childbearing age in China is shown in Figure 3. The source for the data used in Figure 3 (as well as for the following two Figures) is the National Fertility and Family Planning Survey, which was carried out by the State Family Planning Commission (SFPC) of China in October 1992. For its sample, it used 385 000 persons, including 73 946 women aged 50 and below who were or had been married, representing China as a whole, including all individual provinces. In Figure 3 we can see clearly that there was an inverse relationship between educational attainment and cumulative fertility: more schooling was associated with lower cumulative fertility.

From the 1992 survey data, we can see there is considerable variation from one province to another in the relationship between the educational level attained and fertility. Women in the provinces of Liaoning, Jilin, Heilongjiang and Jiangsu, for example, rank high in educational attainment and have relatively low fertility. In Jiangsu, the educational level reached was 5.8 years and illiteracy stood at 22.3 %. There are provinces, however, for which both the educational level and fertility level is relatively high. For example, in Guangdong women of childbearing age also averaged 5.8 years of schooling but with a fertility level of 2.4 births per women the province was ranked at only the seventeenth lowest in the country. When all provinces are considered, there was a slight negative correlation between average years of schooling and fertility level, but the relationship was not remarkable.

The Effect of Education on Fertility

Education cannot affect fertility directly: rather there are other determinants such as age of marriage and contraceptive use. The increase in the number of years of schooling of Chinese women has had a strong influence on the age at which they first marry. As has been documented among other populations of women, educational attainment has led to a reduction in levels of fertility among Chinese women by delaying the age of first marriage and thereby shortening the childbearing period. The 1992 survey showed that the average age at first marriage for the combined groups of Chinese women who had secondary school or college education was 23.5 years. Women with an average of seven years of education or more were about four years older when they married and had 2.2 fewer births than women with no formal education. Women with a college education were on average 1.2 years older when they married than were women with secondary school education (see Figure 4). With China's young people attaining higher levels of education over the past five decades, the age of women at first marriage has shown an upward tendency as well. Data from the population sample surveys in 1982 and 1992 reveal that the mean age for Chinese women at first marriage increased from 18.5 years in the 1940s to 19.0 years in the 1950s, 19.8 years in the 1960s, 21.6 years in the 1970s, and 21.9 years in the 1980s.

The drop in the number of early marriages during the last five decades has been partly due to the increased educational attainment of young people of childbearing age and partly due to the information, education, and communication efforts of the family planning programme and its advocacy of later marriage. National surveys conducted in 1982 and 1988 both showed that, among different education groups, women with a secondary school level of

education had the lowest rate of contraceptive use, possibly because this group consisted of younger women and had a higher proportion of childless women. Family planning policy in China has resulted in great differentials between the level of contraceptive usage and the number of children. The differentials in education appear very small.

Figure 5 shows that the pattern of contraceptive use by women according to their education was very different when the number of children was taken into account. Among the childless, the use of contraceptives was higher for women with the highest education level indicating a greater interest in delaying the first birth. For women with one child, the higher educated showed a higher contraception usage. For women with two or more children, there was a very high usage by all educational groups; 92.3% for women with no formal education, 93.8% for primary school educated, 93.3% for junior high and 93.6% for senior high or above.

For childless women in urban areas, contraceptive use was shown to rise as education increased but in rural areas the figures were equally very low among all educational groups. For the women with one child, the figures for each educational group were consistently higher in urban areas compared with 79.0% in rural areas, and, for women with higher education, the figure was 92.6% in urban areas compared to 87.9% in rural areas. The findings imply that both education of women and rural/urban residence have some independent effect on contraceptive use levels.

The pattern of contraceptive use according to the education level of women shows that those with a higher education were less likely to use female sterilization but that there was a higher proportion using IUDs and other methods. In both rural and urban areas, women who had attained the highest levels of education were

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more likely to be non-users of contraception than were less-educated women. The majority of the women in the two most highly educated groups were not using contraceptives because they wanted to become pregnant, or were breast feeding. This implies that larger proportions of more highly educated women did not use contraception because they were younger, not because of their higher educational status.

Conclusion

Through the historical examination of the relationship between educational attainment and fertility, it is clearly evident that education cannot reduce fertility immediately or that fertility decline closely follows increases in educational attainment levels. It would take several decades of improved educational attainment to reduce TFR. In those countries, like China, where population control is urgent, the education programme should, therefore, be combined with the family planning programme.

Findings from the survey also show that men's and women's education influence the fertility pattern differently. Women with college education postpone marriage on average by 1.2 years beyond that of their counterparts with secondary school education. The average age of marriage for the combined group of Chinese women who have either completed secondary school training or college training is 23.5 years. The influence of men's educational level on family size was found to be less. With seven years of formal schooling, men, on average, fathered 1.3 fewer children than their male counterparts with no educational training.

Education has been one of the intervening variables that have helped lower the fertility rate by being an important determinant of Chinese women's fertility behaviour. Education development is thus

a valuable support for the family planning programme in China. The family planning programme could therefore be helped by continuing improvements in the field of education. Although the role of national level polices in reducing family size has clearly been strong, women's new educational opportunities have, however, been significant in shaping provincial and the rural-urban differences in the rate of fertility decline.

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Figures

Figure 1: Total fertility rates, China 1950-1994

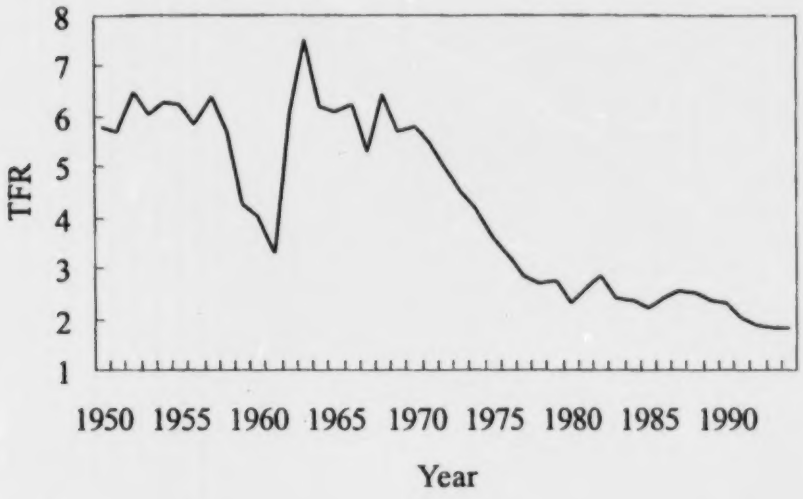

Figure 2: Primary school completed proportion, China

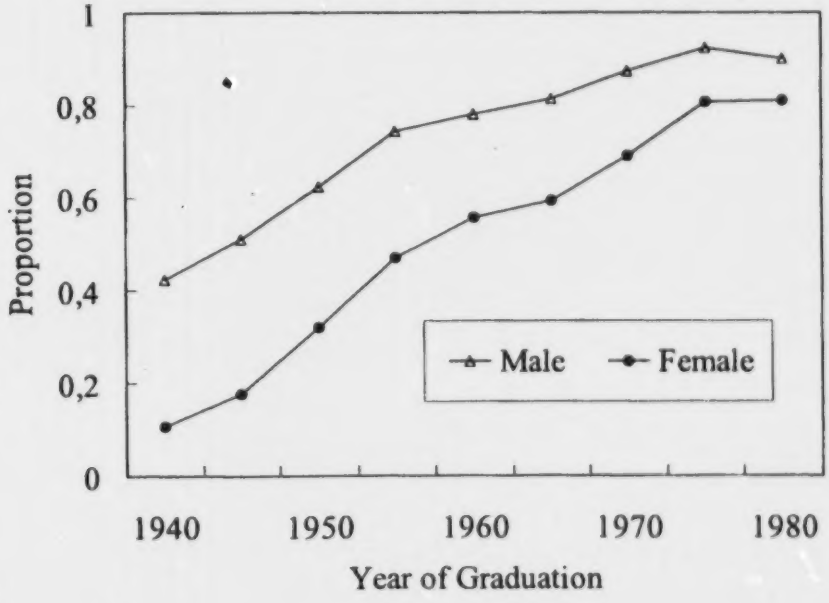

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Figure 3: Age-specific cumulative cohort fertility rate of women of childbearing age by educational level, 1992

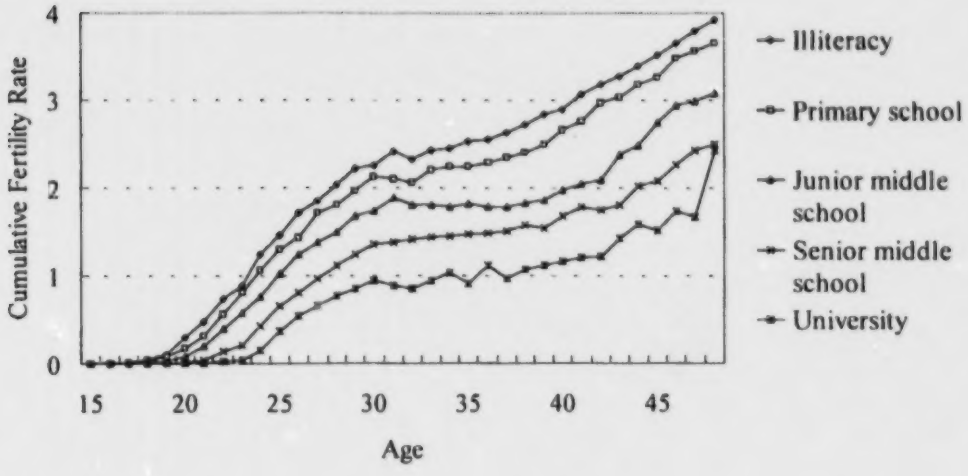


Figure 4: Mean age at first marriage by educational level, 1992

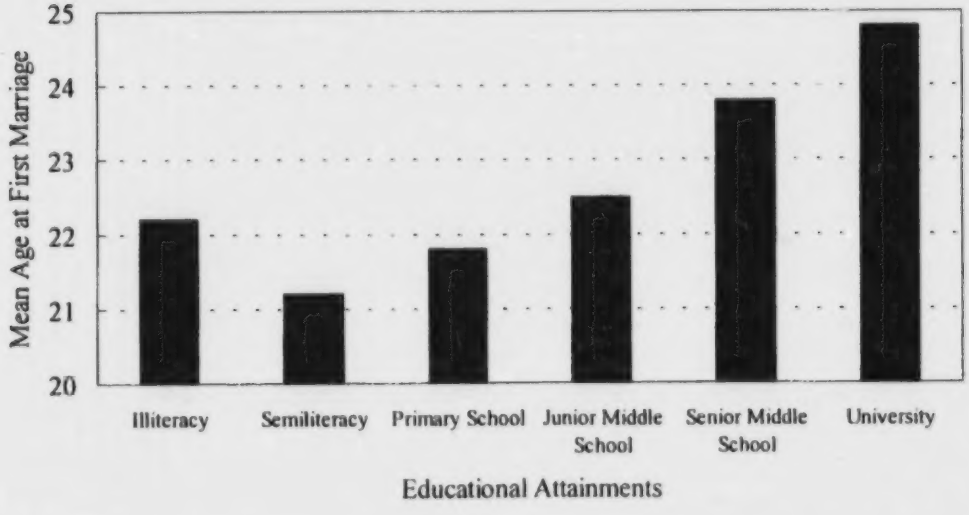
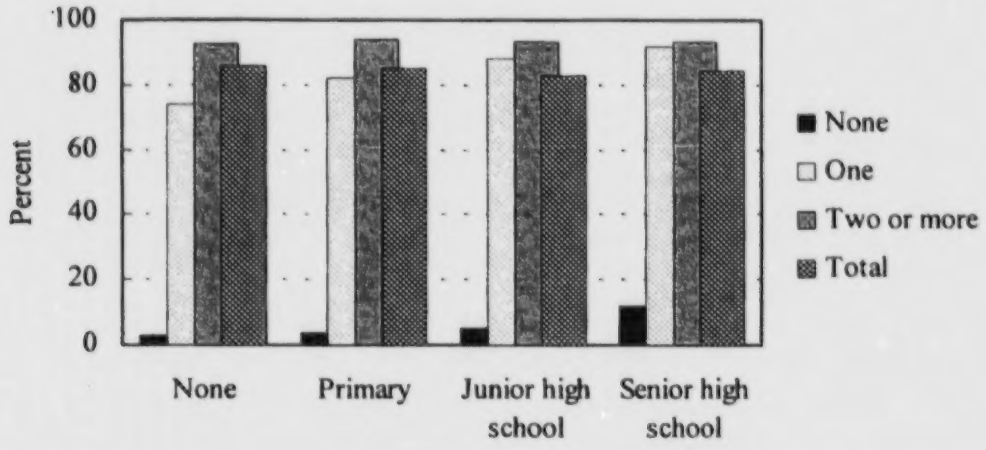


Figure 5: Percent of women currently using contraception by number of children and educational level, 1992



Chapter 9

Adult Education and Population in Ghana: Strategies for Empowering the Ghanaian Woman

Miranda Greenstreet

Introduction

Ghana lies on the West Coast of Africa and has an estimated population of 18.2 million inhabitants made up of different ethnic groups. The country has experienced a high rate of population growth over the past 75 years ranging from 2.6% - 3.1% per annum (see Table 1).

This rapid growth rate has resulted in the population having a young age structure with almost half the population being between 0-14 years. The general improvement in health facilities has also contributed to a higher life expectancy. Consequently, whereas fertility has remained relatively high (Total Fertility Rate is 5.5), mortality has been declining. According to preliminary analysis reports (GSS, 1995), 4% of the population are aged 65 years and over. At the same time, 51% of the population is economically active. This means that between 1970 and 1984, the dependency ratio increased by 6.1 per cent. Several factors account for the high population growth rate in Ghana: education, or rather the lack of it, is one. Studies, such as that by Gavin (1975), have found a strong relationship between high population growth and low levels of education. The positive link between education and socio-economic well being was reinforced by the World Conference on Education For All in 1990 when it declared that "effective human development can contain and even reverse the current threat of economic stagnation and decline".

Ghana's efforts at economic development can be accelerated if women, who constitute 51% of the population but who make up only 23% of the literate adult population (GLSS, 1998), are given enhanced access to education. Women with higher education are shown to have lower birth rates. Empowering the Ghanaian woman through education has therefore become an important factor in population policy.

In Ghana, various studies such as Caldwell (1969, 1980) and the Ghana Demographic and Health Survey (GDHS, 1993) have found that fertility falls as the time spent in education increases. In fact, the GDHS observed that women with no education have an average of 6.7 children whereas those with secondary/higher education have an average of 2.9 children. This same survey also found that women's access to education has been steadily increasing. For instance between 1979 and 1993, the proportion of uneducated women within the ages 15-49 years decreased from 52 to 35%. In comparative terms, however, it is felt that the proportion of uneducated women within the Ghanaian population is still too high, and therefore, there is a need for concrete programmes to help empower Ghanaian women to realise their full potential.

Education

Although educational provision in the country has been gradually improving, it is still inadequate. There is also evidence of significant disparities. According to statistics released for the 1988-1989 academic year by the Ministry of Education, primary school enrolment was relatively high (72% of the school-going age group). However, there is a high drop-out rate, so that by the end of grade one, the primary school drop-out rate was as high as 40%. Various socio-cultural and economic factors such as early marriage, finance and the negative attitude of parents to girls' education account for the low school enrolment and high drop-out rates among girls. The low literacy rate, especially

among females, has an adverse effect on their social and reproductive behaviour as witnessed by both the high fertility and relatively high mortality rates the country has experienced. These in turn impact negatively on the quality of life of the majority of Ghanaians. Although there is no doubt that improved female education will help raise the quality of life, through better child care and nutrition for example, especially in the rural areas, it will also contribute to the reduction in the fertility rate and consequently help to slow down the rapid population growth rate in the medium and long term.

With the educational reform in 1987 the first period of education was established as nine years and provides the basic education to which every Ghanaian child and adolescent is supposed to have free access (primary plus secondary). This is followed by three years of high school which prepare students for university or higher education establishments.

Currently, Ghana has three well-established universities and two fairly new ones. In addition, courses at the six existing polytechnics are being upgraded to meet university level standards. In principle, access to these higher institutions is equally available to both males and females. In practice, however, access has not been uniform for all the regions of the country despite the provision of facilities. Coupled with this is the socio-cultural prejudice against the education of females. It can therefore be argued that there is disparity between the education of the girl child as opposed to that of the boy child.

As has already been noted, a high level of illiteracy exists. By 1996, illiteracy among males in some areas was still as high as 54% and that for women was even higher at 74%. In some of the regions, such as the three northern regions, the illiteracy rate for women still remains well over 90%. In view of this, the government has invested a lot of money in non-formal education in an effort to boost the literacy drive begun in the fifties. This has developed into a country-wide functional literacy programme

which does not merely teach literacy but attempts to educate illiterates in various aspects of their economic, political and social life. Reflecting this, the country's budgetary allocation for education rose from 20% in 1970 to 26% by 1992. Currently, the allocation for education stands at approximately 40% of recurrent expenditure.

According to the 1984 Census Report, 26.3% of females aged 6 years and older had never been to school. The figure for males is 17.2%. The situation has improved somewhat for, according to the Preliminary Report (GDHS 1993), the percentage of all females with formal education increased from 60% to 65% between 1988 and 1993. The GDHS 1993 also shows that the percentage of males with no education was 24.7% against 35% for females.

Despite the large amount of money invested in education and the attempts at achieving educational equality, women are still very disadvantaged. In March 1998, the Ghana Statistical Service (GSS) released the results of the 1997 Core Welfare Indicators Questionnaire (CWIQ) Survey. This was designed to furnish policy makers, planners and programme managers with a set of simple indicators for monitoring poverty and the effects of development policies, programmes and projects on living standards in the country. According to this survey, the literacy rate in Ghana is 47.9%. The rate for males (62.3%) is considerably higher than that of females (36.4%). The urban rate of 63% is significantly higher than the rural rate of 39.9%. Of Ghanaians aged 15 and older, 38.3% have never attended school. The corresponding proportion for the rural areas is 45.5% while that for the urban areas is 26.1%. In both rural and urban areas, however, the proportion decreases with increasing poverty quintiles.

Empowerment of the Ghanaian Woman Through Education and Reproductive Health

In a study (Greenstreet et al, 1997) on the reproductive health of Ghanaian women and the associated problems that impede the development of their potential some interesting findings emerged. In comparing the male and female respondents in the study, it became evident that the female respondents were very deprived. For instance, whereas only 8.8% of the males had little or no education (i.e. less than one in ten), 41.7% of the females fell into this category. This implies that two in every five female respondents did not go to school or had only the barest minimum of primary school education. This would not give them the ability to cope fully in today's society. As for middle school education, 45.6% of the males had benefited from education at this level whereas only a quarter of the females (25.3%) had. From these findings it is therefore clear that as many as 67% of the women studied did not have the capability to operate independently in today's competitive environment. This figure would have been even higher if the sample used in the study had included many in the age group of 50 years or older.

In the case of the secondary school, the proportion of girls, though still low, was more encouraging. Female respondents who had attained this level constituted 16.3% whilst the corresponding figure for male respondents was 22.1%. From the high school level, which is more or less equivalent to the old system of secondary school and secondary technical school, the differences were smaller but nonetheless the male percentage was higher than that for females.

It seems clear that, despite attempts to encourage the education of the girl child, women still lag behind men, particularly in rural areas. It should also be emphasized that education has become the major determinant for placing people in the modern formal sector. Many women, therefore, grow up to discover that they have been left behind as far as the basic

placement in significant social positions is concerned. Achieved status tends to elude them and their frustration is even more pronounced when they later realize that some of their former colleagues who happen to have had a good education have attained much higher positions.

Both males and females in the study expressed the desire to return to school, if only they could have the chance. The males would like to go back to technical schools and the females to institutions where vocational skills are taught in the hope of getting involved in trade or business, including dressmaking and hair-dressing.

The Rights of Ghanaian Women

In Ghana, women and men enjoy equal rights under the law as successive constitutions since independence, including the present 1992 constitution, have ensured. But socio-cultural factors and attitudes, as already stated, hinder the advancement of women. Thus, although in principle women and men enjoy equal rights, in reality, as a result of unequal educational opportunities, women are severely handicapped in participating fully in national development or in taking advantage of available opportunities. Despite the legal rights that both men and women are expected to enjoy, in certain parts of Ghana, particularly in the Volta Region, some inhumane traditional systems exist. Here I wish to highlight the Trokosi or Fiasidi system which is largely prevalent in the North and South Tongu, Ketu and Akatsi Districts. This is a system where females are sent to shrines where they are kept in bondage to atone for the sins or crimes committed by their ancestors. Various organizations have intervened to try to get these women liberated but the practice is proving difficult to stop. So far, 672 Trokosi from 13 out of 52 shrines have been liberated leaving about 4 000 still in bondage. Those liberated are subsequently rehabilitated by various NGOs and equipped with skills to enable them earn an income to take care of themselves.

Here, too, education and legislation are needed to prevent such practices.

Women and children constitute about 70% of Ghana's total population. Therefore, the reproductive role of women in terms of childbearing and childcare and their productive role in the national and domestic economic spheres is significant. It should be stated that over 55% of women are engaged in agriculture, but they tend to be growing food to satisfy their own domestic needs. 24% of women are employed in the retail and distributive trades, but most are found working at the lower levels. 14% of women are in manufacturing. However, a sizeable number of Ghanaian women are in the informal sector where there is less security, making them more vulnerable to even slight variations in the economy. Yet despite their meagre earnings, the informal sector has been one of women's major resources for survival in Ghana, and for that matter in most parts of Africa.

In the past five years, less than 10% of all political-administrative office holders have been females. Currently, less than 20% of the academics in the tertiary institutions and less than 10% of the occupants of top management and decision making positions in public enterprise boards and the trades' union movement are women. All these statistics show not only the limited size of women's participation in the economy, but also give some indication as to why the government is placing so much emphasis on the education of females through educational reform.

Population Policy and Women's Issues

The 1969 Population Policy made provision for institutional arrangements that would seek "to encourage and promote wider productive and gainful employment for women; to increase the proportion of girls entering and completing school and to develop a wider range of non-domestic roles for women" (Republic of Ghana, 1969). The 1992 Population Policy of Ghana similarly emphasized that females should be encouraged to advance

educationally, socially, economically and politically so that they can participate in public life at all levels including decision-making. There is growing concern in Ghana about the worsening social and economic conditions of the very poor and the increase in the hardship of most women.

According to the Action Plan of the 1992 Population Policy, policies and programmes would be formulated to help ensure, among other things, the contribution of women at all levels, in order to promote equity between women and men and provide the conditions and services that are conducive to such contributions. The economic potential of women would also be promoted by providing them with opportunities for education, training, literacy programmes and employment as well as programmes that would give priority to the special needs of women, particularly rural women.

Improving the Status of Women in Ghana

In order to raise the low status of women there is a need to increase participation of females in both formal and non-formal education programmes by actively supporting them socially, financially and psychologically. Wider gainful employment opportunities for women in both the formal and informal sectors need to be developed as well as support mechanisms that enhance the legal status of women.

To achieve these objectives, various projects and programmes are being implemented by both the government and NGOs, including the churches. For instance, in the area of formal education, organizations such as the Forum of African Women Educationists (FAWE) and USAID have been offering support to girls in the form of financial assistance and food aid to help them remain at school, particularly in the Northern Regions of Ghana. The government has also signed an agreement recently with the World Food Programme (WFP) under which more food aid will be available for girls who remain at school. Girls in the

beneficiary schools with a school attendance of at least 85% per month will qualify for a food ration of 8kg of maize and 2kg of oil each. The project will be concentrated in rural schools with the lowest enrolments of girls and involves the use of parent-teacher associations and school management committees. Kpando in the Volta Region has also witnessed an improvement in the lives of its potter women since the start of a project by the Institute of Adult Education. The village women, provided with literacy skills by the IAE, have now formed a co-operative and purchase their clay and other materials in bulk. They also started a revolving loan scheme with the assistance of IIZ/DVV, the German Adult Education Association. In the area of health, Save the Children - Ghana began a Family Reproductive Health Programme in 1995 in partnership with local NGOs with a view to enhancing technical capacity and developing national expertise to identify, implement and manage reproductive health programmes. Save the Children and the Ministry of Health have also collaborated to improve the health needs of women in Northern Ghana. Community Health Nurses are released by the Ministry of Health to work with the local NGOs and to assist with the training and supervision of traditional birth attendants (TBAs). Finally, the Federation of Women Lawyers (FIDA) has also been educating women on their rights and responsibilities in society. The members handle child maintenance and other issues free of charge whenever women cannot afford to pay lawyers. Along with others, they have also successfully campaigned for new legislation to protect the interest of women. This includes, the Interstate Succession Law (PNDC Law 111) and the Registration of Customary Marriage Law (PNDC 112), passed in 1985, which permit a surviving spouse and children to gain access to the property of a deceased husband.

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Conclusion

It is evident that education is one of the main tools for empowering Ghanaian women to realise their full potential in all spheres of human endeavour, including reproductive health. To this end the government should enforce the free and compulsory universal basic education for both males and females to at least the secondary school level. Intensive education should be given to rural illiterate women by organizations like the National Council on Women and Development (NCWD), adult education institutions and the other NGOs. Adult education should help bring about attitudinal change so that through education both men and women would be given equal opportunities in life.

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Tables

Table 1: Population Growth in Ghana between 1921 and 1997

Year	*Population (in millions)*
1921	2.1
1948	4.8
1960	6.7
1970	8.6
1984	12.2
*1994	16.0
*1997	18.2

* These figures are estimates.

Chapter 10

Gender and Health Education: The Incidence of Cervical Cancer in Jamaica

Patricia Rodney

Introduction

This paper examines cervical cancer within the context of the overall health of populations in the Americas, describes the services offered and analyzes those factors which may contribute to the incidence of cervical cancer in Jamaica which is one of the highest in the region. It examines measures taken by the state to address the issue and highlights the fragmentation of service delivery throughout the island. Recommendations are made to complement and improve policy, education, service and access.

Health care services in Jamaica, which were free prior to the 1980s, are now provided for a nominal fee, but if one cannot afford to pay the fees, they are waived. The government is responsible for providing health care to its citizens and as such, owns 95% of the hospital beds in the country. Health services are provided from 372 primary health clinics and 24 hospitals.[1] In each parish there is at least one hospital and over 20 health clinics. Approximately two thirds of Jamaican physicians are private practitioners, and as a result, many of the doctors that work in the public sector have private afternoon practices. Access to primary health care services, however, is hampered by a lack of resources, including travel expenses to and from health care providers, user fees charged by public health clinics and loss of income due to time taken off from work.[2]

The Ministry of Health is the governmental body responsible for managing health care in Jamaica. To ensure that the public sector is receiving adequate services, the Ministry works in conjunction with other ministries and various non-governmental agencies (NGOs) in the areas of service provision and management, developing policies and programmes. For example the Bureau of Women's Affairs, which is a Division of the Ministry of Labor, Social Security and Sports, works with the Ministry of Health to identify inadequacies in basic services that are provided for women. Services monitored include water, sanitation, transportation, public safety, health and education.[3] *The Jamaican Cancer Society*, an NGO that works with the Ministry of Health and other ministries to treat and prevent cancer in the population,[4] is responsible for monitoring cancer trends, developing and implementing interventions and providing public information about cancer.

Structural adjustment macroeconomic policies required a decrease in health expenditures and as a percentage of total expenditure, health expenditure fell from 7.2% to 5.2% between 1982 and 1995. This resulted in a reduction of medical supplies, deterioration of the health services infrastructure, severe shortages in health care personnel and a marked decline in preventive, routine health maintenance. There was a corresponding decrease in the use of public sector services and an increase in the use of private sector services due to an overall decrease in the quantity and quality of public health care.

Rural communities' access to healthcare is hampered by transportation and communication problems. Many areas lack utility lines, thus lacking the ability to communicate via telephone or television, and poor road conditions make it unsafe for vehicular travel. Often these rural areas are also the most impoverished areas on the island. Women from these areas report concern about adequate education for their children,

improved roads, better communication services, job training skills and the development of community centres. Reported health indicators of rural women also reveal higher fertility rates and increased illness due to sexually transmitted diseases - these women are at a higher risk of developing cervical cancer.

Economic development has resulted in a worldwide increase in female-headed households. In North America, close to 30% of all households are headed by women, however, in the Caribbean, the percentage is even higher. Jamaica, for example, has one of the highest prevalence of female headed households in the world, some 42 percent.[5] It has also been determined that female headed households' health expenditures, as a percentage of total expenditures, is lower than similar male headed households. Furthermore, health expenditure data is not stratified by gender or age and therefore it cannot be determined how much is invested in women's, men's or children's health. It should be noted that women may have multiple partners to increase their income levels. However, these practices can increase the risk of contracting sexually transmitted diseases and exposure to violence.

Cervical Cancer in Jamaica

As in the U.S., the most common forms of cancer among males include those of the prostate, stomach and lung; and among women, breast and cervical cancer are most prevalent, accounting for 45% of all cancer cases between 1958-87 (see Table 1). Reports indicate that Jamaica has the highest cervical cancer incident rate, 36 per 100 000, in the Americas. This more than likely is due to a lack of cancer screening; according to the Family Planning Board Reproductive Health Survey of 1997, only 15% of eligible women had been screened for cervical cancer. Currently there are no formal island wide screening programmes, although Pap smears are available at some health

centres, the University Hospital of the West Indies, Family Planning Clinics, private physicians' offices and the Jamaica Cancer Society.

Research on cervical cancer has been carried out in Jamaica since the early 1970s. Since the establishment of its first clinic in 1972, the Jamaica Cancer society has been actively engaged in screening programmes in its five offices. The screening for cervical cancer takes the form of a Pap smear, physical inspection and palpation of the breasts. The cost of this service presently stands at J$300 (approximately US$8.57), but women who cannot meet this cost are not denied service. However, since many women are not aware that the fees can be waived, they do not attempt to utilize the services.

It is estimated that roughly 85% of women have not been screened for cervical cancer. Data is kept in the various health clinics, the Jamaica Cancer Society office and the Information Services Bureau of the Ministry of Health. The health clinics keep records of screening results and treatments, while the Information Services Department keeps track of cervical cancer related mortality. The Jamaica Cancer Society compiles the information and produces various cancer statistics. However, there is no systemic method for island-wide data collecting and reporting.

A cervical cancer project sponsored by the French Cooperation and implemented by the Pan American Health Organization in Barbados and other Eastern Caribbean countries ended in 1996. The findings from the project were to be utilized for the prevention and control of cervical cancer in all CARICOM countries and has resulted in the establishment of screening programmes across the region as well as the development of a set of recommendations including:

- setting of specific screening goals for women;

- definition of procedural responses to positive screening results;
- identification of methods and goals for providing education and information on cancer to the community, specifically targeting the population at risk;
- development of research projects - database development, cost-benefit studies, quality assurance procedures, and recall and follow-up processes for women tested;
- standardization of screening, classification of cervical cytology and pap smear evaluation procedures
- collaboration between government, NGOs and the private sector in developing and implementing screening programmes;
- requests for national, regional and international organizations to continue to support national efforts to control and prevent cervical cancer, i.e. resource mobilization, technical support.

There are additional plans for addressing the cervical cancer problem in Jamaica; however, these are in the project development phase. The Jamaican Cancer Society, University of the West Indies and the Bureau of Women's Affairs are collaborating to launch a systematic island wide-screening programme in conjunction with the Ministry of Health. The programme utilizes the established network of Health Centres and the Jamaica Cancer Society's mobile screening unit, and will perform Pap smears as well as treat STDs and precancerous lesions.

Cervical Cancer and Education

Jamaica is classified as a developing nation and records one of the highest death rates from cervical cancer which is classified as preventable by a low-cost, "low-tech" medical intervention:

a Pap smear. Jamaican women of similar economic status, experience high incidences and high mortality rates of cervical cancer. These women have low educational levels, low-paying jobs, form a high percentage of female headed households and as well as beginning sexual activity early, are likely to fall into a high risk category for other chronic non-communicable diseases and low life expectancy.

According to Earl Jarrett, Chairman of the Jamaican Cancer Society "the country (including the policy-makers) does not have the will to combat the disease". In addition, Jamaican women are constrained by a lack of access to basic health care due to the introduction of user fees and the costs of Pap smear and other diagnostic tests. Loss of income for time away from work may also influence the decisions of these women to seek care.

Educating women does have a positive affect on the health of the family; however, formal education is not always the only way to advance the knowledge level of a population. Non-formal instruction such as radio programmes, health fairs, community theatre, training and other health promotion activities, which are developed within the cultural framework of the audience, are alternative strategies. This is particularly important in outreach for young sexually active adolescents and young women as a more practical or arms-length method to reduce risky behaviors and change attitudes. The empowerment of women with knowledge of reproductive health issues, and in particular cervical cancer, in conjunction with screening and treatment, could have a major impact on cancer-related morbidity and mortality in both countries. This is because women who can comfortably identify early signs of cervical cancer, such as intermenstrual, postcoital or postmenopausal bleeding, can significantly increase the probability that the disease can be

caught and treated, thus reducing the high morbidity and mortality rates.

Conclusion

Despite the high incidence of cervical cancer in Jamaica there are currently no programmes proactively providing women and/or young girls with reproductive health education that address methods of preventing cervical cancer. Females only receive reproductive health related information when they visit the Cancer Society or a health clinic. The state cannot effectively address the cervical cancer problem with its present health infrastructure. However, plans are in place to enhance quality and access to health care services and to inform women of their reproductive health choices. When this happens the incidents of cervical cancer should be reduced significantly

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Table 1: Number of cancer cases by site of occurrence, and proportion of total cancers, in males and females in Kingston and St. Andrew, Jamaica, 1958-1987

Site	*Males*		*Females*	
	Number	*Percentage*	*Number*	*Percentage*
Prostate	966	12.2	--	--
Stomach	864	10.9	560	5.0
Respiratory System	850	10.7	247	2.2
Skin	505	6.4	551	4.9
Lymphatics	430	5.4	307	2.7
Colon	395	5.0	530	4.7
Breast	--	--	2837	25.0
Cervix Uteri	--	--	2261	20.0

Source: Pan American Health Organization. 1997. *Health Conditions in the Caribbean.* Washington, D.C. (Scientific Publication No. 561)

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Chapter 11

Reproductive Health, Education and Risk in Cuban Society

Alina C. Alfonso León

Introduction

Cuba is known world-wide for the excellence of its medical services. Since the Revolution, the government has concentrated its efforts on developing a public health care system and on ensuring free access to medical services for the whole population. Indicators relating to the health of the population reflect these very real improvements and there has been a shift from infectious to degenerative diseases as the main causes of morbidity and mortality.

Government health policy has also focused on the training of human resources and currently Cuba has one doctor per 176 inhabitants. Yet, despite formidable achievements, health attitudes of the population relating to preventive medicine in the field of sexual and reproductive health are not always optimum. In this paper, the inter-relationship between educational level, sexual and reproductive health and risk taking is examined. In the first section, the results of a national survey considering preventive measures for female cancer related to reproductive health namely, breast and cervical cancer, are presented. In the second section a different survey on knowledge of the risk of HIV/AIDS in relation to formal years of education is described.

The National Survey on Health Risk Factors

The National Survey on Health Risk Factors was conducted in 1995 by the National Institute of Health, Epidemiology and

Microbiology and the National Statistics Office, in order to evaluate the attitude of people regarding their health. The target group of the survey was the population over 15 years of age living in urban areas of the country. Because of the difficult economic situation, it was not possible to cover the rural areas.

In the survey 14 304 people were interviewed, about 46.2% were men and 53.8% were women. In the questionnaire, people involved in the survey answered questions linked with their habits regarding smoking, alcoholism, practice of sports, preventive activities and there was a section exclusively for women on reproductive health. The sampling of the survey was inflated, in order to represent the whole population, therefore the results of the survey represent 6 299 813 people out of the whole Cuban population, that is, 57.4%.

The first section of the questionnaire contained a set of questions on general characteristics of the people such as sex, age, educational level, skin colour, marital status, employment and economic condition.

In Table 1 information relating to the educational level of those surveyed is presented. As can be seen, most people had finished secondary school or higher. About 54.6% declared that they were employed and most of them were government workers and civil servants. Some 31.7% of those questioned were pensioners. Of these, 56% reported a low educational level. This constitutes a focus group where non-formal education methods can be used to increase knowledge on health risk attitudes, taking into account the ageing process faced by Cubans. The use of the media and IEC activities in communities and neighbourhoods can be a good way to approach this population which, on the one hand, is already out of the school system and on the other hand, may be less open to changes in their attitude because of their age.

The final section of the survey was devoted to reproductive health and was focused on the female population. The questions

related to the practice of the Papanicolaus test for cervical cancer, breast examination by a doctor and self-examination of the breast. In Cuba, mortality owing to cervical cancer and breast cancer shows an increasing trend and is one of the main causes of death among women (see Graph 1).

The programme for the detection of cervical cancer is extremely well organized allowing for completely free tests every two years for all women. This service is offered in all clinics and there is also the possibility for women who are not able to go there to get the service at home. As can be seen in Table 2, the coverage of the test is very high at all educational levels due to intensive publicity through conferences and the media and also through the work of the community doctors. 83.3% of women who had primary school education only, and 82.9% of university trained women had all undertaken regular Papanicolaus testing.

Unfortunately, the response of the female population towards breast examination by a doctor and self-examination of the breast is not as positive as to the Papanicolaus test. The results of the survey showed that 73.4% of the population had not had a breast examination by a doctor in the twelve months prior to the survey. This response is strongly linked with tradition and with the attitudes of women. Educational work needs to be done in a very sensitive way in order to persuade women to join this preventive health care service. As can be observed in Table 3, at all educational levels, the proportion of answers in the negative varied between 64.3% and 95.3%.

The AIDS Situation

In Cuba at the end of 1998, 2 159 people were already infected with HIV, of these 811 have AIDS already and 577 died because of diseases provoked by the infection. The most important cause of infection was unsafe sexual relations. This applied to 68.4%

of those infected and of these 37.2% were bisexual or homosexual and 31.2% heterosexual. Unfortunately, the epidemic is on the increase in Cuba; in 1998, an increase in the group of heterosexual men was detected and probably that will produce increased risks for women. Cuba has devoted a large amount of resources to IEC activities in the field of sexual education and prevention and has made many efforts for early detection of HIV-infection.

To obtain information and to evaluate the impact of those programmes the "Survey on Prevention and infection of HIV" was conducted in Havana in 1996. This survey was sponsored by the Panamerican Health Organization and was conducted by the National Statistics Office and the National Centre for Health Promotion and Education. The target group of the survey were persons included in the age group 15 to 49 years. The survey covered all the municipalities of the capital city and 3 564 people participated and were classified according to educational level.

The survey found that although men and women to a large extent (more than 97%) have knowledge of or at least have heard about AIDS, less then 25% used a condom and fewer than 35% knew of suitable methods to prevent AIDS. The survey results show that the use of condoms and knowledge of AIDS prevention increases with educational level (see Table 4). According to the data in Table 4 those who completed either secondary school or university have a high level of knowledge of AIDS. Among those with only primary school level this proportion is not as high as in the other levels, only 89.4%. The use of condoms and the number of people who stated they had knowledge of suitable methods to prevent AIDS increased with educational level. Despite this fact, it is interesting to highlight the low use of condoms. In the higher educational levels this is less than 30% and of those adults who only attended primary school only 12.8% of the population stated they used condoms.

In general, the population was unaware of suitable methods to prevent AIDS. Under 50% of university educated people were aware of how to prevent the disease and this proportion decreased dramatically according to educational level. Of those with primary school level education only 18% were aware of suitable methods to prevent AIDS.

Around 84.5% of the population were aware of the fact that people already infected with HIV seemed to be healthy. Most people also think that there is little or no probability they will be infected with HIV; 59.1% said there was no possibility and 30.2% little possibility. 7.5% of the population did not know. The low use of the condom at all educational levels is a situation that needs particular attention in educational programmes to prevent HIV/AIDS.

Most people stated they were ready to take care of a relative who suffered from AIDS, only 12.3% replied negatively and 2.4% were undecided. The higher the educational level the more people are prepared to take care of an HIV-infected relative (see Table 5).

In general, this is a good sign regarding the improvement of knowledge of HIV/AIDS; people are responding more positively and with greater concern towards AIDS patients. However, both in the field of cancer prevention and in HIV/AIDS prevention through condom use, adult learning programmes need to be further developed to meet these reproductive health challenges.

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Tables

Table 1: Population included in survey according to educational level

Educational Level	*Total*	*Male*	*Female*
Illiterate	1,8	1,5	2,1
Primary School (not finished)	9,8	8,0	11,5
Primary School	16,1	15,3	16,8
Secondary School	29,3	30,2	28,5
Apprentice	0,8	1,4	0,3
High School	18,7	20,5	17,0
Technical Training	13,6	12,7	14,4
University	9,8	10,4	9,4

Source: Database National Survey on Health Risk Factors Cuba 1995.

Table 2: Percentage of women undertaking Papanicolaus test

Educational Level	*YES*	*NO*
Illiterate	71,8	28,2
Primary School (not fin.)	72,7	27,3
Primary School	83,3	16,7
Secondary School	85,6	14,4
Apprentice	79,3	20,7
High School	78,7	21,3
Technical Training	83,3	16,7
University	82,9	17,1
TOTAL	82,3	17,7

Source: Database National Survey on Health Risk Factors Cuba 1995.

Table 3: Percentage of women undertaking medical breast examination

Educational Level	*YES*		*NO*
	Family doctor	*Another doctor*	
Illiterate	15.9	3.2	81.0
Primary School (not fin.)	14.4	6.9	78.7
Primary School	18.0	6.2	75.8
Secondary School	19.7	8.1	72.2
Apprentice	4.7	0.0	95.3
High School	16.4	11.4	72.2
Technical Training	19.0	11.3	69.7
University	21.1	14.6	64.3
TOTAL	17.9	8.7	73.4

Source: Database National Survey on Health Risk Factors Cuba 1995.

Table 4: Knowledge of AIDS and condom use and relation to educational level

Educational level	*Knowledge of AIDS*	*Condom use*	*Suit. Methods*
Primary School	89.4	12.8	18.3
Secondary School	98.2	21.1	27.8
University	99.3	28.0	49.6

Source: HIV/AIDS Survey 1996.

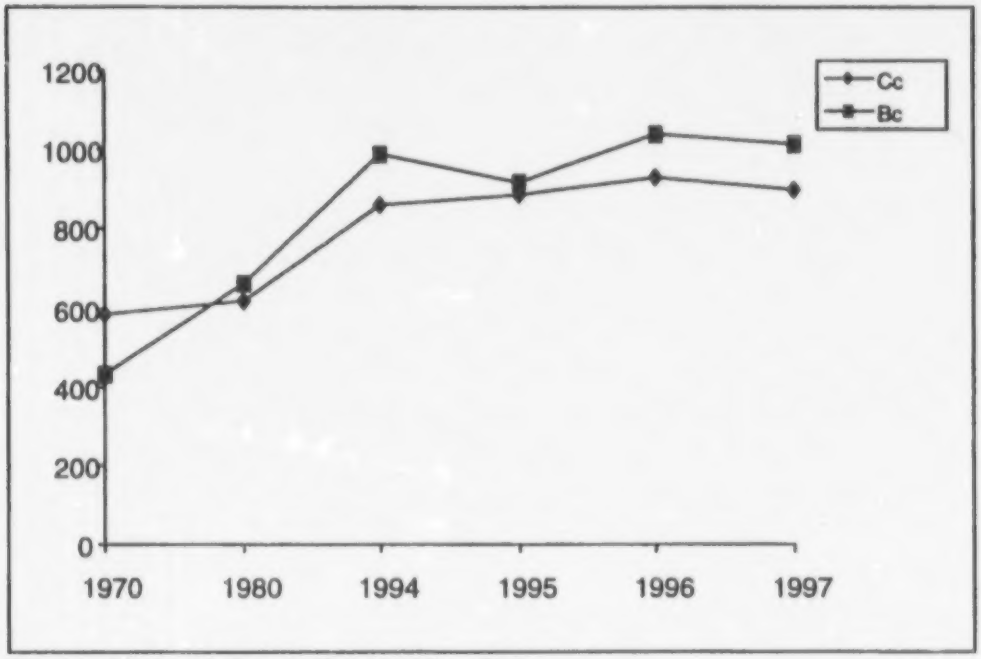
Table 5: Readiness to care for HIV-infected relative

Educational Level	*YES*	*NO*	*Undecided*
Illiterate	54,0	14,6	31,4
Primary School	74,4	15,9	9,7
Secondary School	82,5	14,7	2,8
Apprentice	51,7	43,8	4,5
High School	88,8	10,2	1,0
Technical School	93,2	6,0	0,8
Teaching College	95,0	5,0	0,0
University	96,1	3,3	0,6
TOTAL	85,3	12,3	2,4

Source: Survey on HIV/AIDS Cuba 1996.

Graphs

Graph 1: Mortality by cervical cancer (cc) and breast cancer (bc)



Source: National Cancer Registration Cuba.

Chapter 12

Sex Education in Cuba: Recent Initiatives

Maria Antonia Torres

Introduction

The Cuban National Education System has a network of centres across the entire length and breadth of the country that comprises 12 235 schools and 16 Higher Education Institutes. There are a total of 2 180 892 students, 50% of which are female. In Cuba, the community regards its school as the most important cultural centre on account of its potential in the field of social responsibility and the sustained high numbers attending school. The educational system has been designed as a group of organically linked subsystems comprising the following: pre-school education, general polytechnic education, special education, technical and professional education, training and in-service training of teaching staff, adult education and higher education.

Education in Cuba is today taking place within a socio-political context, which is known as the Special Period, characterized by austerity and economic restriction. In spite of the impact of the Special Period, however, between 10 and 11% of the Gross Domestic Product (GDP) goes to the field of education, evidence of the special attention given by the state to this sector and which together with Public Health and Social Security are a priority.

The universalization of education in Cuba has permitted the entire population, irrespective of race, creed or socio-economic class, to have free access to it. Women have the right to receive professional training and to be placed in managerial posts. Only

3.8% of the population is illiterate, the average level for the population is 9th grade, 99.4% of the population of 6 to 11 year olds and 97.4% of 6 to 14 year olds attend school. There is a ratio of one teacher to 43 inhabitants, all teachers in primary education have the appropriate qualifications and 93% of secondary school teachers are graduates in education.

Since 1991, a process of change has been taking place in education showing evidence of both a reforming and innovative nature. On the one hand, greater importance is given to innovation and the promotion of flexibility and democratization, whilst on the other hand, modifications are being made to the curriculum and alternative working methods are being used both in formal and non-formal education.

Adult Education

The number of students registered in the adult education system is 107 020 of which 56% are women. The presence of young people in this type of education, in contrast to the initial years of the Revolution, has led to the need to redesign the syllabus and to perfect educational methods in order to motivate students and improve communications. Adult education bears the social responsibility for providing workers and adults in general, with the necessary basic educational knowledge to equip them for their subsequent technical training. It includes the following levels: Education for rural workers, foreign language teaching and informal community education via what is known as the "Informal Educational Path". Adults are also able to prepare for a trade or technical profession through the technical and professional education subsystem.

The Informal Education Path

The essential principle of the informal educational paths has been the structuring of initiatives between the different sectors - public health, culture, sport, the Federation of Cuban Women (FMC), Committees for the Defence of the Revolution (CDR), The National Association of Small Farmers (ANAP), Organization of Cuban Workers (CTC), the media, People's Councils and the National Commission for Social Preparation.

Co-ordinating groups have been created to implement this programme at national, provincial and municipal levels and at the level of the people's councils. The selection of staff, the paths to be taken, the mobilization of society and the community and the constant evaluation of this experience has been the responsibility of the co-ordinating groups. Courses in literacy are taught by qualified teaching staff who, in addition to their teaching obligations as part of their work, are responsible for dealing with the illiteracy which still exists in the country. All 7 103 members of the adult education teaching staff are involved in one way or another in the development of the community education programmes intended for those outside the educational system, who in turn amount to more than 166 432 participants.

In order to satisfy the very diverse and growing learning needs of young people and adults, different types of studies have been considered for the adult education subsystem, as have other teaching and training methods taking account of community requirements as well as open learning and distance learning. courses involving meetings are the most commonly used type of distance learning. Meetings take place every week or every fortnight between teaching staff and students, making up a network covering the entire country with 25 000 people registered on distance learning courses. Experimental projects are also being carried out in 11 of the 14 provinces in the

country using local radio and alternative, informal programmes of study.

These action programmes make use of the radio owned by economically important centres of work, such as tobacco factories, which have hundreds of workers. In these courses the workers discuss topics related to, amongst other things, family education, sex education, moral education and standards of behaviour, history of the tobacco industry and the struggles of the workers. New plans and study programmes are also in progress to extend distance learning in an organized fashion and as a non-curricular study alternative for introduction into different regions of the country. The development is continuing of Parents' Schools or Family Education Schools and the Informal Education Path. Worth mentioning are the community programmes: "Educate your child" (aimed at families with children aged 0 to 5 years who do not attend children's groups) and the social communication programme *For Life* promoted by UNICEF.

The Concept of Sex Education in the National Education System

Viewed from the perspective of integral education, the issue of sex education in Cuba seeks to improve the quality of life of society in general. There is a particular concern to see that it should be endorsed at the highest level of government so that, with the assistance of other organizations and institutions, priorities can be established in educational policy. The Ministry of Education, with more than 20 years of experience in this work, is partly responsible for the National Programme for Sex Education, together with the Ministry for Public Health, the Cuban Women's Federation and the Union of Young Communists.

Sex Education in the national education system is seen not as an individual subject, but rather as a series of core ideas

integrated into the entire school curriculum, extra-curricular activities and family education. The work undertaken received a great boost in 1996 with the approval of the project entitled "Formal Education for Responsible Sexual Behaviour", financed by the United Nations Population Fund. This is being carried out in 158 selected secondary schools and institutes of higher education in those regions of the country with the highest incidence of teenage pregnancies, abortions and marriages among young people, all of which are causes of absence from the school system.

The setting up of participatory school projects is the crux of the work in schools and requires the commitment and involvement in sex education by students and their parents. Activities involve the training of teaching staff preparing them to identify educational problems and needs in specific circumstances and to develop curricular and extra-curricular activities. There is an emphasis on strengthening the methodological basis through evaluation coupled with research into and improvement of sexual education by working both with the adolescents themselves and their families.

It was established from the start that school activities should be based on the participatory research approach, which is in harmony with current thinking on human sexuality and education. The project is not confined solely to the accumulation of knowledge about those problems of sexual and reproductive health which are most apparent in the adolescent stage, rather the focus is on the needs of these adolescents so that they can be dealt with through reflection and active involvement. As a result of the project, communication between teaching staff and pupils and between parents and children has improved significantly; the number of clubs, interest groups and scientific societies has increased and various types of backup material have been produced.

Conclusion

The financial support obtained has made it possible to publish a collection entitled "Education and sexuality, towards responsible and happy sexuality", made up of seven pamphlets, one aimed at the technical teams and three for primary, secondary and pre-University teaching staff respectively. Others are aimed at the family and another to adolescents. Videotapes on 21 sex education themes are available for training teachers, parents and students with video activities, such as discussions and workshops to consider the problems.

Even though it is not yet possible to evaluate changes of attitude, a decrease in the number of absences from school due to early marriage has been recorded in 5 provinces. The experience gained motivated the decision to extend it across the entire country by applying the theoretical framework and the methodology to all centres of the national education system in the framework of a national programme of sex education. The educational centres continue to raise the quality of education in the fight to improve the quality of life of our people and as a foundation for its permanent development. This constitutes Cuba's reply to the fulfillment of the principles of the Programme of Action of the 1994 International Conference on Population and Development (ICPD) in the direction of promoting "equality between men and women, the responsibilities of men and the autonomy and empowerment of women... the fostering of well-being from infancy, especially in girls... the right to avail oneself of information and of the means necessary to do so".

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PART IV:

THE ROLE OF NGOs

Chapter 13

The Role of Adult Education in Population Issues in Zimbabwe

Mercy Hatendi

Introduction

Zimbabwe is a patrilineal society where close to 70% of the people live in rural areas, the majority of whom are women. Zimbabwe has traditionally placed little value on women's participation in activities outside the home. In the past, while women's childbearing and nurturing roles were acknowledged, very little recognition was given to their actual or potential contribution to the overall development of the country. This situation was further aggravated by the colonial economic realities of the labour market, which required that males be educated to work on the farms or in the factories and industries as semi-skilled labourers and to become capitalist-oriented consumers. There was very little room for women's participation in formal employment and, as a result, there were very few opportunities for black women to enter educational institutions. Thus, as men were being groomed to embrace the new socio-economic order, women were neglected and continued to engage in their old traditional roles. The few who were lucky to receive some education ended up as cooks, baby-minders and housekeepers and, at best, as teachers and nurses.

For a long time, both cultural and traditional norms and the colonial socio-economic policies militated against women's advancement and worked in union to foster female inferiority and dependence on their menfolk. Women's inferior status had a negative impact on virtually every aspect of their lives. In legal issues, for example, women were minors from the cradle to the

grave, passing from the guardianship of their fathers to that of their husbands upon marriage. This made it impossible for a woman to enter into any contract without the backing of the man, even if he was much younger. In the event of the death of her husband or divorce, she could not become the guardian of her own children since she was considered a minor. At the same time, the minority status of women meant that they had no control over the fruits of their labour, such as the crops they grew or the income they earned.

This left the women overtly dependent on men for economic support, and their inferior status meant that most decisions outside the kitchen were referred to the male head of the family. Women had no control over the land they tilled though they had limited land use rights. In health matters, the minority status of women both culturally and legally meant that they had no control over their reproductive health and sexuality such as deciding on the family planning method, number of children, spacing of pregnancies and seeking medical advice. The fact that women were less empowered than men to manage their sexual and reproductive lives limited their ability to protect themselves in adolescence and adult life from sexually transmitted diseases (STDs), HIV/AIDS, unwanted pregnancy and coercive sexual relations. In addition, as a result of discriminatory activities and cultural tradition, girls have been subjected to harmful practices such as sexual abuse that have had grave consequences for their health and well being. Since Zimbabwe gained independence, this situation has been changing and the quality of life for women has started to improve. The Government established the Ministry of Community Development and Women's Affairs, which amongst other improvements has facilitated women's participation in politics and by 1995, there were 21 female parliamentarians out of a total of 150.

The Role of Adult Education in Promoting Reproductive Health

The Department of Non-formal Education was established within the Ministry of Education to address the problem of the high illiteracy level, which existed at the time of Independence. At that time, women accounted for more than half of the illiterate population in Zimbabwe. In 1981, women's illiteracy stood at 60% but had been reduced to 45% by 1983 as a result of an adult literacy and mass education campaign organized initially under the Ministry of Community Development and Women's Affairs but which was subsequently taken over by the Ministry of Education. The Department focuses on adult literacy and functional literacy.

Rural populations, in particular women, are the main beneficiaries of the adult literacy programme. However, although enrolment in adult literacy courses continued to rise tremendously until 1990, there has since been a continuing decline due to the poor conditions of service for teachers.

The functional literacy strategy was drawn up to target the specific educational needs of peasants and workers while emphasizing such matters as primary health care, the environment, population issues, family life and co-operative education. This strategy helped beneficiaries, in particular women, function in the working environment and benefited their general social conditions and health.

In addition, the Department of Adult Education at the University of Zimbabwe has continued to train personnel to work in the field of adult education. It has also established a Department of Health Education to train health education officers. The Ministry of Health and Child Welfare has also been involved in primary health-care and has implemented a number of programmes to create awareness about family planning and reproductive health, including STDs, HIV/AIDS and safe motherhood.

Zimbabwe's achievements in family planning have been a success story. Contraception has been well accepted, and is on the increase: 31% (1980), 35% (1994), 62% (1997). The use of contraception is higher in urban areas and increases in its usage also correlates with the increased educational attainment of the women. The pill is the main method and is used by 80% of women. Family planning is, on the whole, greatly valued for improving both the quality of life and that of maternal and child health.

The National AIDS Co-ordination Programme (NACP) was established within the Ministry of Health to address the severe problem of HIV/AIDS in Zimbabwe. It is estimated that approximately 700 people die of AIDS every week. Moreover at least 25% of the adult population is HIV positive, with one in four adults being infected by HIV. Approximately 60% of reported AIDS cases in the country occur among young adults between the ages of 20 and 30 years. As in many other developing countries, the main mode of transmission for HIV is through sexual intercourse. This form of transmission has resulted in HIV/AIDS cases being highest among those in the reproductive age group (20 - 39 years) and among infants (from birth to 5 years).

To enhance adult education activities, programmes to train village community workers, traditional birth attendants, environmental health technicians and agricultural extension officers have also been initiated.

NGO Initiatives and the Role of the Women's Action Group

As well as the various government initiatives in the field of adult education, NGOs, such as the Musasa Project and the Women's Action Group (WAG) have been formed. The Musasa Project offers counselling and public education on violence against women. WAG promotes the economic, social, political, legal, educational and cultural advancement of women in Zimbabwe

and also promotes women's rights. Adult education tends to be considered in Zimbabwe as primarily an instrument for the advancement and emancipation of women and this accounts for many NGOs involved in promoting women's quality of life or women's development (including WAG) being deeply involved in adult education.

WAG is an NGO that was formed in 1983 in response to the indiscriminate arrest of around 6 000 women for going out at night alone in various towns and cities of Zimbabwe. The initial purpose of the pressure group was to protest against the violation of the rights of these women, who were being labelled as prostitutes. The organization has evolved since 1983 to become a leading local NGO which seeks to promote, protect and defend the economic, health and legal rights of women.

WAG's objectives are to increase public awareness of women's health, human and legal rights in Zimbabwe, to carry out projects that promote the rights and interests of women, to advocate gender sensitive policies, and to network with other organizations that focus on women's issues. WAG's activities have always been in response to women's needs. The Health Information Programme was launched in June 1990 after delegates at their 1989 conference indicated that they wanted more information on health matters affecting women. As the woman is a caregiver in the home, it was natural that her own health should be a priority, too. Women wanted to know how to prevent certain conditions or how to cope with existing ones. As a result, a health information needs assessment survey was conducted in all provinces of Zimbabwe, using sample groups from different areas. Findings of the survey revealed that:

- There was inadequate information on reproductive health, including STDs and HIV/AIDS.
- Healthcare providers had negative attitudes towards women seeking health services.

- There was a serious shortage of resources in the health sector.
- Some people still had to walk long distances (of more than 10 kilometres) to the nearest health centre.
- Men were not involved in health information, which targeted women.
- The process of obtaining assistance through the Social Dimensions Fund for the poor was a difficult one.
- The number of diseases/conditions were cited in order of priority. Conditions pertaining to reproductive health were at the top of the list.

WAG responded to inadequate information for women on reproductive health by producing a series of six health booklets in English, Shona and Ndebele. The booklets, entitled "Getting To Know Our Bodies", are distributed free. The topics of these booklets focus on: the reproductive system; menstruation and menopause; women and cancer; pregnancy and infertility; STDs, HIV/AIDS; aches and pains.

The booklets form the basis for discussion in the workshops on reproductive health that are held at grassroots, ward, district and provincial levels throughout the country. Radio programmes on various health conditions are also broadcast. Women are advised to seek further clarification or information by writing or by visiting the office.

A video on cervical cancer entitled "Take Care" was produced, again in the three national languages. The video has been distributed to all the provinces of Zimbabwe as well as to other organizations involved in reproductive health. Health information dissemination has helped women to value their time whenever they have health problems. Evaluations done within the organization have demonstrated that some women are now able to articulate their health problems. In addition, counselling is provided to women with various health problems although

these are, as already observed, mostly centred on reproductive health. Workshops have been held with nurses, general staff, nurse aids and clerks in hospitals to make them aware of the importance of positive communication with people seeking help. Further workshops have been held with nurses, local women and local leaders to improve communication and foster a better appreciation of each other.

Using adult education as a vehicle, WAG provides:

- Family planning counselling, information, education and communication.
- Information on pre-natal and post-natal care, safe delivery, breast-feeding and the prevention and treatment of infertility.
- Information on prevention and treatment of infections of the reproductive system, including STDs.
- Information, education and counselling on human sexuality, sexual and reproductive health, responsible parenthood and effective prevention of STDs and HIV. This is important because, in some areas, women's lack of control over their sex lives has led to early sexual initiation and greater exposure to STDs, resulting in high incidences of infertility as well as death due to AIDS.
- Promotion, supply and distribution of condoms. This includes instruction in their use and suggestions as to how a woman, often at a disadvantage in sexual issues, can improve her negotiation skills.
- Information on the predisposing factors to cancer, its early detection and prevention, particularly of those forms like cervical and breast cancer that only affect women. For example, women are advised to examine their breasts monthly, to have cervical smear tests done and are discouraged to use vaginal herbs or chemicals.

- Information and counselling services to women who have experienced any forms of violence.

Accountability and Health Education

One important aspect of WAG's work has been to call attention to the use of the public budget. WAG analyzed the government's budget trend through its network "Your Health is Your Right Campaign" and found that it had dropped in the period 1991 to 1995. The budget plans for 1996 were therefore monitored closely since they did not appear to be taking into account inflation or the increase in cases of HIV/AIDS. Several public meetings were held on these issues and members of parliament were lobbied before the country's budget was debated and passed. It was at this stage that WAG, realizing how little power members of parliament have when it comes to budgetary issues, decided to intensify the campaign. Other NGOs also joined in to demand the participation of all citizens in the preparation of the country's budget.

Attitudes are now changing. In one province (Mashonaland Central Province) where WAG's health programme has been concentrating its efforts there is evidence that care providers and clients have developed a mutual appreciation of each other. A government commission has also been set up to look into the provision of health care in Zimbabwe as a whole which WAG regards as a victory since it demonstrates that the government itself admits to the existence of poor healthcare services. It is hoped that this commission will reveal the host of problems that WAG itself has identified and recommend useful solutions. Although WAG cannot get all the credit for putting women's health on the agenda, it is apparent in Zimbabwe that policy-makers now appreciate the value of good reproductive health care.

And WAG now participates in strategic planning meetings of the Ministry of Health and Child Welfare on women's health

and health issues in general. The organization works closely and collaborates with other NGOs working in this field. Although we cannot yet claim victory in our lobbying efforts, the seeds of our advocacy work are starting to germinate and demonstrate the power of well-focused civil organizations in different domains.

Conclusion

In the belief that effective, preventive healthcare depends largely on empowering people to manage their own health, based on reliable information, WAG, through adult education, has managed to establish a gender- and culturally-sensitive information, education and communication programme on reproductive health. The organization launched public education campaigns in support of sexual and reproductive health rights. These have covered such issues as safe motherhood, family planning, valuing rather than discriminating against the girl child, child abuse, violence against women, male responsibility, gender equality, STDs, HIV/AIDS, responsible sexual behaviour, the prevention of teenage pregnancy, and the early detection and treatment of breast, cervical and uterine cancers.

Adult education has enabled NGOs to raise women's awareness of their rights in areas of sexuality and reproduction although culture can be a barrier to these rights being exercised. It has also allowed them to address the needs of girls and young women through health information programmes on issues such as nutrition, the physiology of reproduction, reproductive and sexual health, family planning, STDs, HIV and AIDS prevention. Directed at parents and involving community leaders so as to ensure acceptance and support, these programmes also focus on gender relationships and equality, violence against adolescents, sexual violence and abuse, responsible sexual behaviour, unwanted pregnancy and reproductive health.

We believe above all that improved education for women and girls contributes to their ability to make informed decisions

about their own lives, improves their status within the family, delays the age of marriage and, in many cases, motivates a desire for smaller manageable families. Furthermore, increasing women's education improves the chances of survival and development of their children.

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Chapter 14

One Night in Bangkok

Wilas Lohitkul

Introduction

The Kingdom of Thailand with a population of 64 million is situated in the centre of South-East Asia, and is the only country in the region never to have been colonized. Although the rule of absolute monarchy came to an end in 1932, and since that time Thailand has had a constitutional monarchy with a strong, centrally controlled government administered by a Council of Ministers, the Thai people have deep links with the king, the nation, and religion. These elements are intrinsic to Thai society. The national religion of Thailand is Buddhism and more than 90% of the population is Buddhist. The Buddhist temple has always been the centre of all important village activities, and the influence of Buddhism on the Thai way of life and mode of thought is profound.

The Population and Community Development Association

The Population and Community Development Association (PDA) founded in 1974 as the Community Based Family Planning Service (CBFPS), initially aimed to complement the efforts of the Royal Thai Government to promote family planning in urban and rural areas of Thailand where knowledge and access to such services were scarce. This extensive, community-based network of family planning volunteers now covers one third of the entire nation and has contributed significantly to the decrease in the population growth rate in Thailand from 3.2% in 1970 to 1.2% in 1997.

The success of PDA's community-based approach to family planning encouraged the Association to adapt the same strategy to other development needs in Thailand. Since 1979, PDA has implemented a variety of integrated health and community development programmes which include primary health care, water resource development, environmental conservation, community forestry, small scale industries, the building of local development institutions, AIDS prevention, training, and research and evaluation. PDA has also tapped the skills and support of the corporate sector through the Thai Business Initiative in Rural Development (TBIRD) which participates directly in rural development and AIDS prevention efforts.

Much of the success of PDA's work in the field of public health can be attributed to its co-operation with other government and non-government organizations. A steering committee in family planning chaired by the Minister of Public Health was formed to set guidelines, approve implementation areas and co-ordinate policy-making in central and regional offices. The steering committee consisted of the four major NGOs involved in family planning together with representatives from the Ministry of Public Health. Pooling resources and liaising with the relevant agencies meant that the public received a much clearer message and had improved access to materials. Regardless of the organization concerned, close co-operation was found to be the key to family planning success in Thailand.

PDA's programmes operate on the principle that an integrated set of services, addressing various health and economic needs, will more effectively improve fertility management and the overall quality of life than a one dimensional, family planning, health or income generation programme. It is difficult to develop a strong programme in a context of poverty with a fragile infrastructure and lack of trained personnel. Thus, PDA combines its development policies

to accelerate income growth and reduce poverty with those intended to expand educational opportunities and promote a smaller family size. These programmes by working simultaneously, have a much greater social, economic and political impact.

Underlying all the activities is the belief that individuals, if given the chance and access to resources, are capable of determining and fulfilling their own development needs. A fundamental feature of PDA's programmes is the participation by villagers in each phase of the project development, including monitoring and evaluation. In an atmosphere of mutual respect and trust, community development efforts eventually become self-perpetuating.

Adult Education Strategies

The Community Based Family Planning Services (CBFPS), which later became PDA, was founded as a way to combat poverty in farming communities by reducing the population growth rate. Previous approaches had been unsuccessful due to the shortage of qualified personnel able to distribute oral contraceptives, and because family planning was a sensitive issue in Thailand. CBFPS proposed that these problems could be overcome by enabling villagers to help themselves through the establishment of a grassroots approach, and using an extensive publicity campaign, which took a humorous approach to family planning.

Hence, a community-based distribution scheme was chosen as an alternative to the existing clinic-based system. Under this system, a respected member of the village or urban neighbourhood was trained in giving family planning advice and contraceptives. This person was selected on the basis of his or her character and their social position in the community. The programme operated successfully because the distributor was

officially recognized by government and received a small financial incentive to recruit as many people as possible, although there was no such incentive for those who attended. The co-ordinator was required to keep records on the supply and sale of materials and educational material was provided to the villagers as part of the promotional campaign.

PDA has, over the years, promoted many unusual and even lighthearted approaches to reproductive health issues. One of these was a condom-blowing contest where participants blew up condoms like balloons. Such actions also helped to make the subject something that could be discussed openly so that, by being commonplace, contraception would be more likely to be used. There is significant factual and anecdotal evidence in Thailand to suggest that this has, in fact, been the case. Along similar lines, condoms were also promoted as useful household items which could be used for storing water, as a tourniquet (for first aid), a coin bag, a hair elastic and on gun barrels to prevent rain getting in. In Thailand, a colour is associated with each day of the week, e.g. Monday is yellow, while Tuesday is pink and Wednesday is green, black is the colour of mourning. Condoms were produced in a variety of colours and their use promoted according to the days of the week. A cartoon-like character named Captain Condom was created and used in stickers and promotional materials. He also appeared 'in person' during condom events and on public transport to create awareness and break down barriers.

Taxi drivers were also drawn into the work. The training of taxi drivers in the provision of family planning materials was undertaken as part of the Taxi-based Family Planning/AIDS/HIV Education Programme which was conducted in Bangkok in 1989-90. It aimed to educate taxi drivers about family planning and AIDS so that they, in turn, could educate their passengers. Taxi drivers were targeted

because they have contact with large numbers of passengers, especially during rush-hour traffic jams, and thus would be able to pass on the safe sex message. PDA trained 700 taxi drivers and supplied them with contraceptives to sell to their passengers and information kits to pass on. The driver's incentive for participation was that they were able to keep a small percentage of cash and kind.

Family Planning Song

As part of the publicity campaign to promote awareness about family planning, PDA also developed a "family planning song" to be taught to schoolchildren. Treating the topic of family planning as something the whole family could discuss removed some of the barriers and sensitivities. Furthermore, the family planning song described the problems of having many children and suggested various methods of family planning. The song went like this:

> *Many, many children we haven't enough to eat, spending money not enough to keep, we are unhappy when having many children.*
> *Many, many children our parent's hearts almost break, we are facing hopelessness because of having many children.*
> *Many, many children don't be frightened and worry (we) are happy to suggest: (pill taken) will prevent many children, (insert IUD) will prevent many children, (injection) will prevent many children, (vasectomy) will prevent many children, (XX) can be changed to anything.*

Young people both in and out of school were encouraged to educate their peers and friends about the importance of family planning and sexually transmitted diseases. It was recognized that the teenage years are important ones for family planning purposes. Getting properly informed teenagers to educate other

teenagers was found to be particularly effective. In addition, during the summer period, PDA conducted teacher training throughout the country. Mobile family planning education teams were sent to train teachers and encourage their support as family planning volunteers. It was hoped that, if these teachers incorporated family planning topics into their subject teaching at school, this would disseminate knowledge about contraception still further in the context of the family. In addition, PDA also runs a mobile vasectomy clinic to try to combat what it perceives as three main problems:

- lack of medical doctors able to provide the service;
- adequate marketing of the service to reach the target group;
- lack of motivation.

A vasectomy project was designed to address these three principal concerns by disseminating information and knowledge about the vasectomy service in order to eliminate misunderstandings and change people's attitudes towards vasectomies, by providing free vasectomy services to people both in rural areas and Bangkok through mobile service centres and clinics, and by studying the project's impact and increase in vasectomy demand while also stimulating interest in other family planning services.

Of particular importance to the success of the project was the marketing approach. The campaign promoted the vasectomy service as a product and it used attractive advertising to get the message across. It also provided a quality product and good after-sale service in the form of free medical check-ups. A vasectomy club for vasectomized men was formed, with members having access to free information, use of facilities and other benefits. In some campaigns, a lottery draw for clients was also held. Other innovative elements of the publicity campaign included vasectomy fairs during public occasions and for

celebrations such as the King's Birthday, the Queen's Birthday, and the National Days of various countries. At these times, the mobile vasectomy vans would provide their services at parade grounds or places where there were large gatherings of people. Since 1981, this has become a tradition. Mobile vasectomy vans also provide this service to rural villages.

AIDS Education

PDA has been actively engaged in AIDS education. Its strategy has three major components. The first is pilot implementation of projects (including educational interventions and materials development) which can then be replicated by others. The second is training of other individuals and organizations so they, in turn, can train and replicate educational efforts by creating a multiplying effect. The third area is that of advocacy: PDA continues to push for more effective and extensive government policies and educational efforts in addition to those provided by other sectors of society (private and international NGOs) and to support the rights of people with AIDS. Recognizing that the range of possible activities falling within this strategy is broad, PDA has focused on four main target groups: women, commercial sex workers, youth and institutional leaders.

The AIDS Prevention Bureau spearheads all AIDS prevention and education activities. The organization currently runs a broad range of AIDS prevention activities - including education, advocacy and some research. In addition to implementing specific AIDS education projects an effort is made to integrate AIDS education activities into all of its ongoing community and rural development projects. Some innovative elements of the AIDS prevention activities include the Compassion Van or AIDS Educational Mobile Clinic affiliated to the Ministry of Public Health (MOPH). The main purpose was to provide AIDS education at businesses, universities, parks

and festivals. In addition, in red light districts, AIDS prevention campaigns were organized with the objective of educating and providing information to commercial sex workers. Activities included anti-AIDS contests and condom distribution.

Work on AIDS prevention has focused not only on adults but also on children. In this context the babies' home was created whose purpose was to accept abandoned babies from HIV positive mothers and provide them with care until testing for the virus took place at 18 months of age. Two thirds of babies born to mothers with the virus test negative, but the earliest age that an accurate diagnosis can be made is 18 months. At this stage, babies testing positively were provided with medical care for the short duration of their lives. Uninfected babies were passed to the Department of Public Welfare, which provides long-term care and arranges adoption for orphaned children. The babies' home operated with the assistance of volunteers and donations.

Conclusion

The Population and Community Development Association has been very successful in introducing and maintaining family planning services in Thailand. Much of this success is due to a policy of assisting people to help themselves and determine their own development needs. By combining programmes, which alleviate several social concerns, rather than using one single approach, it has been done much to improve the living standards of many of the rural poor in Thailand. Success has also been due to the Association's ability to co-operate and co-ordinate its efforts with other relevant organizations, both within the government and externally. The main focus for the future continues to be based on participation of the community, innovative and eye-catching approaches to educational campaigns and strategies and partnership at all levels of society.

Note on Contributors:

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Wilas Lohitkul has a Bachelors of Science degree from Mahidol University, in Bangkok, Thailand. He joined the Population and Community Development Association (PDA) in 1974. With PDA, he has held many positions, notably as Director of the Population Health and AIDS Prevention Bureau. Currently he is Director of the Rural Development Bureau. He also serves as adviser to the Minister of University Affairs and the Bangkok Metropolis Governor.

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Toufic Aziz Osseiran is a founding member and Secretary General of The Lebanese Family Planning Association. He is an expert in the field of Population and Family Planning, as well as a UN consultant in the field of Evaluation. He has more than 35 years of national and international experience. He also served as regional and international treasurer of the IPPF and was vice-

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Questions of Intimacy. Rethinking Population Education examines key areas in the population field in relation to education. Sexuality, reproductive rights and health, masculinities, violence, adolescence, fertility, ageing, gender relations and AIDS education are some of the themes explored in the contributions.

The book is based on selected papers presented at an international expert group meeting held in Cuba on Adult Education and Population, as part of the follow-up activities to the Fifth International Conference on Adult Education (CONFINTEA V). In Part One the book addresses the issue of men, masculinities and health from the population perspective. With contributions from Mexico, South Africa, Pakistan and Lebanon, the stereotypes of male identity are analysed and experiences involving adult learning and the redefinition of gender relations are presented. Part Two looks at population education from a life cycle approach. Authors from Cuba, Mexico and Thailand focus on the concepts of adolescence, intergenerational learning, and ageing. In Part Three the emphasis is on policy making for population education, with perspectives from China, Ghana and Jamaica. Finally, Part Four explores the role of NGOs in population education in particular in two national contexts: Thailand and Zimbabwe.

Questions of **Intimacy. Rethinking Population Education** is essential reading for all those working in the field of population and education, whether policy makers, researchers or practitioners.

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